

062561 AUG 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 7 5 3
REG NO

1 DECEASED NAME (TYPE OR PRINT) CLARENCE ABBOTT			2a DATE OF DEATH MONTH DAY YEAR AUGUST 8, 1987		2b HOUR 2:30 M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 17, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12205 VALLEYWOOD DRIVE		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a STATE MD.			13b CITY OR TOWN MONT.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13a CITY OR TOWN OF DEATH WHEATON			12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GLAZIER		12c KIND OF BUSINESS OR INDUSTRY GLASS CO.
14 FATHER'S NAME FIRST MIDDLE LAST CLARENCE E. ABBOTT			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE - EVANS		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS KATHRYN R. ABBOTT SAME AS # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic transitional cell ca bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>atherosclerotic cardiovascular disease</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Neil Julia</i> MD				22c DATE SIGNED 8/8/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Neil Julia				22e ADDRESS Olney, Md. 20832	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE AUG. 10, 1987		23c NAME OF CEMETERY OR CREMATORY PARKLAWN	
23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT. MD.		24 FUNERAL DIRECTOR NAME ADDRESS MURIEL H. BARBER LAYTONSVILLE, MD. 20879			
25a DATE REC'D. BY REGISTRAR AUG 11 1987		25b REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies with the law, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury or other traumatic event, the medical certificate must be signed by a medical examiner.

BP

083201 AUG 13 01



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FOR
TE
GISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DEATH	MONTH	DAY	YEAR	24 HOUR
	8	20	87	10:15 AM

1. DECEASED NAME (TYPE OR PRINT) LOUIS E Rachel		FIRST LOUIS E		MIDDLE Rachel		LAST ABBOTT		2b. DATE OF DEATH MONTH DAY YEAR 8-20-87		2a. HOUR 10:15 A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 10, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN) France		7b. CITIZEN OF WHAT COUNTRY? France		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aid		12b. KIND OF BUSINESS OR INDUSTRY American Cancer Society	
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5216 42nd Place 20781			
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Maya				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geanne Legraud				16. ADDRESS 192 Sean Circle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-52-6971		17. INFORMANT ADDRESS Michael E. Guerin (Son) Woodbine, Md. 21797							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BLADDER CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) 5 YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a COPD, FIBROCYTIC PLEURISY											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from 8-19-87 to 8-20-87 that (I) (we) lost saw the deceased alive on 8-19-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE J. Kelman				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. KELMAN				22e. ADDRESS 6525 BELCREST Rd, Hyattsville MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 08/23/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia		23e. DATE RECD. BY REGISTRAR AUG 26 1987			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.						25. REGISTRAR'S SIGNATURE John Davidson					
26. ADDRESS 4739 Baltimore Avenue Hyattsville, Md. 20781											

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH23755
REG. NO.

064889 SEP-8-87

1- STATE per funeral home
REGISTRAR

DECEASED NAME (TYPE OR PRINT) IRENE		FIRST Mary		MIDDLE		LAST ADAMS		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 8 YEAR 1987		2b. HOUR 8:40	
3. SEX Female	4. RACE Can	5. DATE OF BIRTH MONTH 03 DAY 06 YEAR 1978	6. AGE (IN YEARS) LAST BIRTHDAY 7 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH 8 DAY 30 YEAR 1987		2d. HOUR 8:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ALVAHOSP HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2208 Chapman Road 20783			
14. FATHER'S NAME FIRST George MIDDLE LAST Oehler				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Radtke				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			
16a. SOCIAL SECURITY NO. 217-44-4881				17. INFORMANT (Husband) George W. Adams				17b. ADDRESS 2208 Chapman Road Hyattsville, Md. 20783			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Cardiovascular dis.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 2 days years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION 8/29/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ventricular Septal Rupture						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Paul A. DeVoe MD		TITLE (SPECIFY) Deputy						DATE SIGNED 8/30/87			
EXAMINER'S NAME (TYPE OR PRINT) Paul A. DeVoe MD		ADDRESS 4203 Queensbury Rd Hyattsville MD 20781									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 08/31/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home P.A.						25a. DATE REC'D BY REGISTRAR SEP 4 1987		25b. REGISTRAR'S SIGNATURE Paul A. DeVoe			
4739 Baltimore Avenue Hyattsville, Md. 20781											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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004889 SEP-0-97



SEP 4 1897

064605 SEP 2 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITALS, ATTENDING PHYSICIANS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner will be notified at once.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Benjamin Adams					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28 1987					2b. HOUR 6:20 P M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 9 1903			6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clergy			12b. KIND OF BUSINESS OR INDUSTRY CHURCH			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9420 WISCONSIN AVE 20814			
14. FATHER'S NAME FIRST MIDDLE LAST William Benjamin Adams					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ola Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1939-1946		17. INFORMANT JEANNETTE G. ADAMS			ADDRESS 9420 Wisconsin Ave. Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 28</u> , 19 <u>87</u> , to <u>AUGUST 28</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E.P. Fox</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/30/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. FOX LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 02, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR SEP 1 - 1987			25b. REGISTRAR'S SIGNATURE <u>Julia F. ...</u>		

BP

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062360 AUG 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23151

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD ADLER			2a. DATE OF DEATH MONTH DAY YEAR 8-5-87			2b. HOUR 12 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 1, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSP'T.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BAKER		12b. KIND OF BUSINESS OR INDUSTRY BAKERY		
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10661 WEYMOUTH ST. #201, 20814	
14. FATHER'S NAME FIRST MIDDLE LAST MAXIMILLION ADLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SELMA MAYER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 424-42-7739		17. INFORMANT IRMA ADLER		ADDRESS (SAME AS ITEM #13)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple brain metastases DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) large cell carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks unknown										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from Aug. 4, 1987 to Aug. 5, 1987 , that (I) (we) last saw the deceased alive on Aug. 4, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE DR. PETER PUSHKAS						DEGREE MD		22c. DATE SIGNED 8/5/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PETER PUSHKAS						22e. ADDRESS 11510 OLD GEORGETOWN Rd, ROCKVILLE MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 8-5-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.C. MD			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.						ADDRESS 20910 SILVER SPRING, Md.		25. RECEIVED BY AUG 10 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 3 7 5 8

1- DECEASED NAME FIRST MIDDLE LAST COLIN EDWARD AGOSTINI			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8-5-87 19			2b. HOUR M 2:20A		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 28, 1965	6. AGE (IN YEARS) LAST BIRTHDAY 22 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-5-87 19		
BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Piney Meeting House Lane nr. Boswell La.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10100 Chariot Court 20850		
14. FATHER'S NAME FIRST MIDDLE LAST Edward M. Agostini				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norma M. Farnum				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-86-3180		17. INFORMANT ADDRESS Edward M. Agostini same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:10AM 8-5-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver of an auto/fixed object impact			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Piney Meeting House Lane Rockville, Md. nr. Boswell Lane			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Margarita A. Korell</i>			TITLE (SPECIFY) Assistant			DATE SIGNED 8-6-87		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24. FUNERAL DIRECTOR Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850					25a. DATE REC'D. BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M
BP
DHMH - 17
(VR A15 ME (S))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY INQUIRY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3759

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
CATHERINE F. ALLAN								8 31 19 87								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
female	Caucasian	Sept. 30, 1907		79 YRS.						8 31 19 87						11:54 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Washington, D.C.		United States		WIDOWED		DIVORCED		Montgomery County								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		3105 Beckenham Ct.		Homemaker		own home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3106 Beckenham Court								20906	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Ewell		Maude														Hutchinson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		283 50 6077		Berry T. Wright, Jr. son,		1701 W. 7th St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease													
		DUE TO, OR AS A CONSEQUENCE OF															
		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?									
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
		P.M. 19		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Ann M. Dixon, M.D.		Deputy Chief		9-1-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Ann M. Dixon, M.D.		111 Penn St., Balto., MD		21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		Sep. 4, 1987		Monocacy Cemetery		Beallsville, Maryland											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert A. Pumphrey Funeral Home		SEP 10 1987		Julia Davidson-Randall													
Rockville, Inc. 300 W. Montgomery Av., Rockville, Md. 20850																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, PM 4, AND PM 5. FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 7 8 0

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH ESTI- MATED			MONTH DAY YEAR			7b. HOUR			
Michael			WAYNE			Allen			8-17			187			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		7c. HOUR	
MALE		WHITE		OCT. 5, 1952		34 YRS.		MONTHS DAYS		HOURS MIN		8-17- 187		5:28P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.				USA								Montgomery County			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				Holy Cross Hospital				SALESMAN				TELEPHONE CO.			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MD.				MONT.				ROCKVILLE				13e. STREET ADDRESS			
												12630 VIERS MILL ROAD 20853			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
RAYMOND L. ALLEN				ZOE - VILLONE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				4005 Sundown Road			
XXXX				215-60-8600				RAYMOND L. ALLEN				Laytonsville, Md. 20879			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Multiple injuries															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
				4:38PM 8-17- 1987				Subject jumped from balcony							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)							
				house-apt.				12630 Viers Mill Road, Rockville, Montgomery CO.							
22a. I certify that I took charge of the remains described above and held on												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
death resulted from												Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE				8-18-87			
Charles P. Kokes, M.D.				Assistant				MEDICAL EXAMINER				SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (CITY OR TOWN COUNTY STATE)			
BURIAL				AUG. 20, 1987				LAYTONSVILLE CEMETERY				LAYTONSVILLE MONT. MD.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
MURIEL H. BARBER				LAYTONSVILLE, MD. 20879				AUG 19 1987				Julia Bender-Ruback			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07 '84
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DHMH - 17
(VR A15 ME (5))

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FOR Items 16a,b,17 Film G630 SB

STATE OF MARYLAND

STATE per Funeral home

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
THE ODORE						ALPER		08 15 87		PM							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	CAUC	10 13 07		79		YRS.				08 16 87						03 40	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
HUNGARY		U.S.A.		WIDOWED		DIVORCED		MONTGOMERY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BETHESDA		5300 RIVER ROAD		MUSICIAN + CAB DRIVER		MUSIC + TAXICAB											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND SECT									
DC		NONE		WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1626 33rd st., N.W.		20007							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
IGNACE		ALPER		REGINA		KRKOWITZ											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> W.W.II <input type="checkbox"/> NONE		188-01-4279		Alyce Alper		IN ALYCE (WIFE) SAME AS ITEM #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				MYOCARDIAL INFARCTION				ACUTE									
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INDEF									
						(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		PM. 08 15 1987		FOUND BACK OF CAR													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		PARKING LOT		5300 RIVER RD BETHESDA MONT MD													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
FRANCIS C MAYLE		MEDICAL EXAMINER		08/16/87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		8200 WILSON AVE BETHESDA MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY		STATE							
CREMATION		8-18-1987		CHAMBERS CREMATORY		RIVERDALE, P.G.C.		Md.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
W. W. CHAMBERS CO. INC.		20910 SILVER SPRING, Md.		AUG 24 1987		John Benson-Rudner											

DIVISION OF VITAL RECORDS, 201 W. WESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING INQUIRY" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. WESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DHMH-17
(VR A15 ME (5))

063774 AUG 28 81

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(11)

W. V. CHURCHES C. INC., SOUTHERN REGION, C.F.C.
CHURCHES C. INC., SOUTHERN REGION, C.F.C.
CHURCHES C. INC., SOUTHERN REGION, C.F.C.

064422 SEP -1 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 7 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SOPHIE ALTMAN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 27 1987			2b. HOUR 4:55 A				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 8 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		9. CITIZEN OF WHAT COUNTRY? UNITED STATES		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
12. CITY OR TOWN OF DEATH BETHESDA		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE VIRGINIA			16b. COUNTY FAIRFAX		16c. CITY OR TOWN MCLEAN		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 1511 LONGFELLOW STREET 22101	
17. FATHER'S NAME FIRST MIDDLE LAST MARTIN STEINBERG			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST YETTA DONENFELD							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -			19b. SOCIAL SECURITY NO. 059-03-5927		19c. INFORMANT ADDRESS SIDNEY J. ALTMAN, 1511 LONGFELLOW STREET,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MCLEAN, VA 22101 METASTATIC BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 16 , 19 87 , to AUGUST 27 , 19 87 , that (I) (we) lost saw the deceased alive on AUGUST 27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>D. E. Lewis</i>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 27 Aug 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. E. LEWIS, LT, MC, USNR			22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/28/87		23c. NAME OF CEMETERY OR CREMATOR Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852						25a. DATE REC'D. BY REGISTRAR AUG 31 1987				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, please see item 18, which shows any injury, or other traumatic event, the medical examiner must be notified.

004455 SEP-1-61

Aug 31 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 7 0 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGARET C. Amstock			2a. DATE OF DEATH MONTH 8 DAY 12 YEAR 1987		2b. HOUR 12:30 P.M.
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH 11 DAY 1 YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST Michael MIDDLE Krause LAST Krause		15. MOTHER'S MAIDEN NAME FIRST not MIDDLE available LAST available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 186-05-4327		17. INFORMANT ADDRESS Anna M. Burch, same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Overdose DUE TO, OR AS A CONSEQUENCE OF (b) Organic Brain Syndrome DUE TO, OR AS A CONSEQUENCE OF (c) years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe degenerative brain disease			
19a. DATE OF OPERATION 1/14/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Feeding Neurosis	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/12 1986 to 8/12 1987 , that (I) (we) last saw the deceased alive on 8/12 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.			
22b. SIGNATURE C. H. Ligon MD		22c. DEGREE MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Ligon MD		22e. ADDRESS 18111 Pt Philip Dr., Olney MD 20832	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 17, 1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814		25. DATE REC'D. BY REGISTRAR AUG 17 1987 26. REGISTRAR'S SIGNATURE J. Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

063057 AUG 18 87

TOG 51 BUA

062511 AUG 13 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23704
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Ward Anderson			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1987		2b. HOUR 2:30 A M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 13 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home		12. OCCUPATION, BUSINESS OR INDUSTRY Dept of Agriculture US Government Retired				
13a. STATE Md.			13b. COUNTY Mont		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Anderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Pigg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes Army			16b. SOCIAL SECURITY NO. 216 44 3636		17. INFORMANT ADDRESS Annie Ross Anderson (Wife) Same as 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>CVA Hemiparesis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/23</u> 19 <u>86</u> , to <u>7/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Edward Richards</u>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-8-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Edward Richards				22e. ADDRESS 10301 Ga. Ave. S.S. Md. Suite 104				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.		
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Woodrow Wilson Pkwy. A.S. Md.				25a. DATE REC'D. BY REGISTRAR AUG 12 1987				
				25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner will be notified of this.

BP

6

062213 AUG 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1. DECEASED NAME (TYPE OR PRINT) YUDIF			FIRST MIDDLE LAST APTEKAR			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 2 1987			2b. HOUR 9:00P M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH FEBRUARY 20, 1919			6. AGE (IN YEARS LAST BIRTHDAY) 68		
7a. BIRTHPLACE (STATE OR FOREIGN) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? none			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH PLACE IS IN STATE OF DEATH) 7620 MAPLE AVENUE			12a. USUAL OCCUPATION (OCCUPATION OR TYPE OF BUSINESS OR INDUSTRY) SCHOOL TEACHER			12b. KIND OF BUSINESS OR INDUSTRY EDUCATION		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7620 MAPLE AVENUE 20912		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN TAKOMA PARK					
14. FATHER'S NAME LEIB			MIDDLE BUNOV			15. MOTHER'S MAIDEN NAME FAGA			MIDDLE GIMPEL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-02-8925			17. INFORMANT ADDRESS SOFYA JACOBS, 11756 CARRIAGE HOUSE DRIVE SILVER SPRING, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Colon Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (a) this hospital attended the deceased from <u>14 July 1986</u> to <u>2 Aug 1987</u> , that (b) I saw the deceased alive on <u>14 July 1986</u> , and that (c) my opinion of death occurred on the date and hour and from the causes stated above (we) (I) did not visit the body after death.											
22a. SIGNATURE <u>Dr. T. A. Bensinger</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/3/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. THOMAS A. BENSINGER, M. D.			22e. ADDRESS 7610 CARROLL AVENUE TAKOMA PARK, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE (SPECIFY) 8/5/1987			23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY ADELPHI			23d. LOCATION PRINCE GEORGE'S MARYLAND		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR AUG 07 1987			25b. REGISTRAR'S SIGNATURE <u>John Henderson-Randall</u>		

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text block]

[Illegible text block]

[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Percy Eugene Archer			2a. DATE OF DEATH MONTH DAY YEAR August 4, 1987		2b. HOUR 2:40a M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 22, 1905		
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		8. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 Whitestone Road		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Montgomery County Govt		12b. KIND OF BUSINESS OR INDUSTRY Liquor Board		13. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Herbert W. Archer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence N. Pettit		16. SOCIAL SECURITY NO. 579-01-6917		
17. INFORMANT friend Stanley P. Nesline		18. ADDRESS 206 Whitestone Road Silver Spring, MD 20901		19. DATE OF OPERATION 6-12-1968		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Carcinoma of prostate.</u>		22. DATE OF OPERATION 6-12-1968		
23. DATE OF OPERATION 6-12-1968		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		28. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		31. LOCATION STREET CITY OR TOWN COUNTY STATE		
32. I certify that (I) (this hospital) attended the deceased from <u>6-12-1968</u> to <u>8-4-1987</u> , that (I) <u>we</u> last saw the deceased alive on <u>7-23-1987</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> <u>did</u> (did not) view the body after death.		33. SIGNATURE <u>Seruch T. Kimble, M.D.</u>		34. DATE SIGNED 8-4-87		
35. PHYSICIAN'S NAME (TYPE OR PRINT) Seruch T. Kimble, M.D.		36. ADDRESS 9801 Georgia Ave, Silver Spring, MD		37. DATE REC'D. BY REGISTRAR AUG 7 1987		
38. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		39. DATE Aug 6, 1987		40. NAME OF CEMETERY OR CREMATORY Gate of Heaven		
41. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		42. ADDRESS 500 University Blvd. W Silver Spring, MD 20901		43. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers		

085125 AUG 10 85

+

VIEW IN

DOCK

20% COLLOMETER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))

062803 AUG 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 707

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			7b. HOUR		
Jose Arpide			8/11/987			0035 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
MALE	WHITE	12 1 30	56 YRS.			8/11/1987	0035 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
SPAIN		SPAIN				Montgomery MD		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Behtesda		Suburban Hospital			UNEMPLOYED			
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS		
MARYLAND			MONTGOMERY	ROCKVILLE	YES <input type="checkbox"/> NO <input type="checkbox"/>	11443 SCHUYLKILL ROAD 20852		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES?			
JOSE			CESAREA		16b SOCIAL SECURITY NO.			
FIRST MIDDLE LAST			FIRST MIDDLE LAST		17 INFORMANT ADDRESS			
JOSE ARPIDE			CESAREA DUANA		JOSE ARPIDE/SON SAME AS 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a)			Cardio Respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			(b) Coronary arteriosclerosis					
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			P.M. 19					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION			
					CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)		DATE SIGNED			
John Tauber			M.D. [Signature]		8-11-87			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS		MEDICAL EXAMINER			
John Tauber			8218 WISCONSIN AVE.		Bethesda MD.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		23e COUNTY
BURIAL			AUG20,1987	CEMETERIO DEL ESTE		CARACAS		VENEZUELA
24 FUNERAL DIRECTOR NAME			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS, JR.			AUG 13 1987			[Signature]		
500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901								

005003 10 14 81

20% COLICUM LIBER

WILHELM



Handwritten notes and signatures at the bottom of the page, including what appears to be a date '10/14/81' and a signature.

063973

AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23708
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FREDERICK ELTON ASH			2a. DATE OF DEATH MONTH DAY YEAR 8 19 87		2b. HOUR 9A M.
3. SEX Male	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 11 13 15		6. AGE (IN YEARS (LAST BIRTHDAY)) 71	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11922 Stonewood Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Psychologist	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11922 Stonewood Lane 20852
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Clarence Ash			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AnnaLee Lyons		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Violet J. Ash (wife) same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) globolema multiforme DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. 1a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 8 , 19 87 , to Aug 19 , 19 87 , that (I) (we) lost saw the deceased alive on Aug 8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. Nicholas Rogentine, Jr. MD				22c. DATE SIGNED 8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. NICHOLAS ROGENTINE, JR.				22e. ADDRESS 10570 SUMMIT AVE, KENSINGTON, MD 20895	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	
23d. LOCATION CITY OR TOWN Rockville, Maryland		23e. STATE Maryland		23f. DATE REC'D. BY REGISTRAR AUG 26 1987	
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. REGISTRAR'S SIGNATURE John Anderson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, this certificate must be filed with the State Dept. of Health and Mental Hygiene.

003254 2-5 2320

063523 AUG 24 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 7 6 9

REG. NO.

1. FOR STATE REGISTRATION		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
FIRST MIDDLE LAST		8 5 87		1255 M	
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		WHITE		MONTH DAY YEAR	
6. AGE (IN YEARS LAST BIRTHDAY)		7a. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
91		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
GERMANY		SHADY GROVE ADVENTIST HOSP.		HOUSEKEEPER	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY	
ROCKVILLE		SHADY GROVE ADVENTIST HOSP.		HOUSEKEEPING	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
D.C.		---		WASHINGTON	
14. FATHER'S NAME (TYPE OR PRINT)		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
ROBERT		ELLA		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF	
578-14-0927		REV. DR. REICHARD		NLH- ROCKVILLE, MD.	
19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
---		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
---		HOUR A.M. MONTH DAY YEAR		---	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION (CITY OR TOWN COUNTY STATE)	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		---		---	
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on above, (I) (we) did not view the body after death.		19 87		19 87	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Thomas E. Dealey, MD		---		5 Aug 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
Thomas E. Dealey, MD		17964 BEEKS RD ARLING		CREMATION	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)	
AUG. 6, 1987		METROPOLITAN CREMATORY, ALEXANDRIA, VA.		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HYSONG CO., INC.-1300 N ST., NW WASH., DC		AUG 21 1987		Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other therapeutic event, the medical examiner must be notified and a death certificate must be filed with the State Dept. of Health and Mental Hygiene.

063253 NOV 24 81

NOV 24 1981

063645 AUG 25 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 77 0

1- FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) LILLIAN VAUGHN AVERY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 12 1987		2b. HOUR 10:40 P M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 18 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED (MAJOR)		12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DISTRICT OF COLUMBIA		13b. COUNTY COLUMBIA	13c. CITY OR TOWN WASHINGTON, DC 20001	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLY UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	
16b. SOCIAL SECURITY NO. 1941-1962 579-52-8365		17. INFORMANT BRIAN R. STEPAN, 7101 8th STREET, NW			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) SMALL CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 27 , 19 87 , to AUGUST 12 , 19 87 , that (I) (we) last saw the deceased alive on AUGUST 12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert Keating</i>		DEGREE MD		22c. DATE SIGNED 14 AUG 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. KEATING, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8-18-1987	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS 20910 SILVER SPRING, Md.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987	
				25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>	

063842 AUG 22 81

4



RECEIVED
JUL 24 1981
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 1 7 1

REG. NO.

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

DONALD WILSON BAILER

7a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR

8 21 87 M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR 4 11 06

6. AGE (IN YEARS LAST BIRTHDAY)

81

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Penna.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10. CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

4201 Heathfield Rd.

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Sales

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Rockville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4201 Heathfield Rd. 20853

14. FATHER'S NAME

FIRST MIDDLE LAST
Wilson J. Bailer

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Jessie Vail16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

216-12-7927

17. INFORMANT

Wheaton ADDRESS Maryland 20902

Wilson J. Bailer 12124 Livingston St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CANCER OF LUNG

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 YEAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 23 APR 19 87 to 21 AUG 19 87, that (I) (we) lost
saw the deceased alive on 6 AUG 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

21 AUG 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

WALTER E. GOOZH, M.D.

22e. ADDRESS

2309 Shorefield Rd, Wheaton, md 20902

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Aug 24 1987

23c. NAME OF CEMETERY OR CREMATORY

Moreland Memorial

23d. LOCATION
CITY OR TOWN COUNTY STATE

Baltimore

Maryland

24. FUNERAL DIRECTOR

NAME

Leonard J. Ruck, Inc. Baltimore, Maryland

ADDRESS

25a. DATE REC'D. BY REGISTRAR

AUG 26 1987

25b. REGISTRAR'S SIGNATURE

John Davidson-Rodriguez

063975 AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3772
REG. NO.FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH CLARA BALAZS			2a. DATE OF DEATH MONTH DAY YEAR AUG. 21, 1987			2b. HOUR 8:26A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 5, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8505 SPRINGVALE RD. #243			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET.-SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY HUNGARIAN REFORM FEDERATION		
13a. STATE Md/				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BALAZS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LIZZIE DEMETER				13e. STREET ADDRESS / ZIP CODE 8605 CAMERON ST. SILVER SPRING, Md. 20910	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 577-03-9039		17. INFORMANT ADDRESS JOSEPH A. BONIS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min 3 yrs 4 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension + Cerebrovascular disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <u>6/9</u> 19 <u>78</u> to <u>8/21</u> 19 <u>87</u> , that (II) we last saw the deceased alive on <u>8/17</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.									
22b. SIGNATURE <u>Geoff Kenton, MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/21/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. GEORGE S. KENTON M.D.						22e. ADDRESS 10620 GEORGIA AVE, SILVER SPRING, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-26-1987		23c. NAME OF CEMETERY OR CREMATORY WILLOW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE OREGON, LUCAS CO. OHIO		
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. INC. SILVER SPRING, Md. 20910						25a. DATE REC'D. BY REGISTRAR AUG 26 1987			
						25b. REGISTRAR'S SIGNATURE <u>Julia Tindon-Randall</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3773

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Peter NMN Banos			2a. DATE OF DEATH MONTH DAY YEAR 8-23-87		2b. HOUR 2:45 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 2, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Carpenter	12b. KIND OF BUSINESS OR INDUSTRY Local 132	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		
13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 11411 Dewey Dr. 20906					
14. FATHER'S NAME FIRST MIDDLE LAST Louis Christopher Banos		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel P. Tsantili			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 151-10-8881		17. INFORMANT ADDRESS Margaret A. Banos (wife) same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>possible MI vs PE.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 mins					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/22/87</u> , 19 <u>87</u> , to <u>8/23/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Shelley Laby - Gottheim, MD</u>		DEGREE MD		22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Shelley Laby - Gottheim, MD</u>		22e. ADDRESS <u>1106 Spring St. Silver Spring, MD 20906</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/87		23c. NAME OF CEMETERY OR CREMATORY Grace Lawn Cemetery	
23d. LOCATION CITY OR TOWN New Castle, Delaware		STATE			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23114

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	8-14-87			1445m
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		
Male		Caucasian		April 6, 1913		74		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Vermont		USA				MONTGOMERY Co. MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA		SUBURBAN HOSPITAL		Real Estate Consultant		employed		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland		Montgomery		Kensington		YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		11a. STREET ADDRESS / ZIP CODE		11b. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST		FIRST MIDDLE LAST		5323 Bangor Drive		20895		
Anthony Barbieri		Gemma Piazza						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
yes		1942-1945		579-22-5413		Kathryn J. Barbieri/wife same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>arteriosclerosis</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/11/1987 to 8/14/1987, that (I) (we) last saw the deceased alive on 8/14/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
<u>Hamid Montakhar</u>		M.D.				8/15/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
HAMID MONTAKHAR		6111 EXECUTIVE BLVD. ROCKVILLE, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Aug 17, 1987		Gate of Heaven		Silver Spring Mont MD		
24. FUNERAL DIRECTOR Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
500 University Blvd. W Silver Spring, MD 20901				AUG 20 1987		<u>Richard H. [Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten notes in the middle section of the page, possibly describing a process or observation.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Wallie K. Barnes

2a. DATE OF DEATH MONTH DAY YEAR
8 11 87 2b. HOUR
4:20 P.M.

3. SEX
Female

4. RACE
Caucasian

5. DATE OF BIRTH MONTH DAY YEAR
Jan. 24, 1900

6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS
87

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York

7b. CITIZEN OF WHAT COUNTRY?
United States

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD.

10. CITY OR TOWN OF DEATH
Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary

12b. KIND OF BUSINESS OR INDUSTRY
Insurance

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN
Maryland Montgomery Gaithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
#408 20879 18700 Walkers Choice Road

14. FATHER'S NAME FIRST MIDDLE LAST
John Walters

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elsie Langjahr

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b. SOCIAL SECURITY NO.
100-24-3051

17. INFORMANT ADDRESS
16515 Grande Vista Dr. Jeanne B. Curtis Rockville, MD 20855

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
(b) Cerebral arteriosclerosis or
DUE TO, OR AS A CONSEQUENCE OF
(c) atrial arrhythmia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
11 days
2 years
4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Rheumatoid Arthritis, Arteriosclerotic heart disease with arrhythmia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from April 10, 1980 to Aug 11, 1987, that (we) last saw the deceased alive on Aug 11, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.

22b. SIGNATURE
James R. Moore Jr.

DEGREE
MD

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED
8-11-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James R. Moore Jr.

22e. ADDRESS
207 Brookes Ave Gaithersburg Md.

23a. BURIAL, CREMATION, REMOVAL
Burial

23b. DATE
August 14, 1987

23c. NAME OF CEMETERY OR CREMATORY
Greenfield Cemetery Hempstead, LI, New York

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Ave. Rockville, MD

25a. DATE REC'D. BY REGISTRAR
AUG 13 1987

25b. REGISTRAR'S SIGNATURE
David R. Rader

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 20 of this form should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. The first part of the report describes the general situation of the project and the progress made during the last period. It also mentions the results of the various experiments and the conclusions drawn from them.

2. The second part of the report deals with the detailed results of the experiments. It includes a description of the experimental setup, the data obtained, and the analysis of the results. The results show that the proposed method is effective in improving the performance of the system.

3. The third part of the report discusses the limitations of the current work and suggests directions for future research. It also mentions the contributions of the various members of the team and expresses gratitude to the sponsors of the project.

4. The final part of the report is a summary of the main findings and conclusions. It emphasizes the importance of the work and the potential applications of the results.

062833 AUG 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 776
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RITA (NONE) BARRETT			2a. DATE OF DEATH MONTH DAY YEAR 8-4-87		2b. HOUR MIN. 5 55 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 5 1 00		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GROSVENOR MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE	12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a. STATE M.D.		13b. COUNTY —	13c. CITY OR TOWN WASH. D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST NED HOULIHAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLEN SCANLON		16. SOCIAL SECURITY NO. 169-07-8907A	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		17b. INFORMANT HESTER A. REIDY		ADDRESS 1757 4 ST. N.W. WASH. D.C. 20009	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (c) —					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 7-1 , 19 87 , to 8-4 , 19 87 , that (I) (the hospital) saw the deceased alive on 8-3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.					
22b. SIGNATURE John Tauber		DEGREE M.D.		22c. DATE SIGNED 8-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS 8218 WISCONSIN AVE BETHESDA MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE AUG-6-1987	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WASH. D.C.
24. FUNERAL DIRECTOR (NAME) Devol Funeral Home		25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

2776

Handwritten notes on lined paper, including the word "STATION" and various illegible entries.



063910 AUG 27 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 1 1 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glenn E Barthe			2a. DATE OF DEATH August 23, 1987			2b. HOUR 0411gm				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH July 19, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Specification		12b. KIND OF BUSINESS OR INDUSTRY G S A				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 109 Upton Street 20850	
14. FATHER'S NAME (TYPE OR PRINT) George Edward Barthe			15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Ida Boyce							

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II		16b. SOCIAL SECURITY NO. 216 01 4732		17. INFORMANT Wife Elizabeth M. Barthe Same as item 13	
---	--	---	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Tachycardia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>suble</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u>		48 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Transitional Cell Carcinoma, Bladder + Prostate</u>			
--	--	--	--

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <u>8-19-87</u> , 19 <u>87</u> , to <u>8-23-87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8-22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE <u>Edward C. Gilbert</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Gilbert, M.D.		22e. ADDRESS 10313 Georgia Ave. S.S. Md. 20902					

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE Aug. 25, 1987		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
--	--	----------------------------	--	--	--	---	--

24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland		25. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

003010 W05201



W05201

064666 SEP-30

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO. 2 3 7 7 8				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERTRUDE Irence BATTER					2a. DATE OF DEATH MONTH DAY YEAR August 28, 1987			2b. HOUR P M 4:30 P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 12, 1894		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 92		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Pr. Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9348 Cherry Hill Road #206 20740	
14. FATHER'S NAME FIRST MIDDLE LAST George Beyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Louise Bedell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO 215-50-3673			17. INFORMANT Son			ADDRESS 11209 Healy Street Wheaton, Md. 20902			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/23 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Wheaton MD					
22. I certify that (I) (this hospital) attended the deceased from 8/23/87 to 8/28/87 , that (I) (we) lost saw the deceased alive above, (I) (we) (did) and now view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22a. SIGNATURE Myron L. Lenkin				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 8/30/87	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN				22d. ADDRESS 2309 SHOREFIELD RD. WHEATON MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 31, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				24b. ADDRESS 500 University Blvd., W. Silver Spring, Md. 20901		25. DATE REC'D BY REGISTRAR SEP 02 1987			

27

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21

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64761 SEP 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR	
Dorothy Battist		Female		Caucasian		Jan, 11 1906		81 YRS		August 30, 1987		7:30pm	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Russia		USA.				Montgomery MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Suburban Hospital		Bookkeeper		Accounting							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Montgomery		Bethesda				9121 McDonald Court 20817					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Ele Barkan		Zelda											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
no		084 32 2246		Lewis Battist: See # 13 above									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/1/86, 19, to 8/30, 1987, that (I) (we) lost saw the deceased alive on 8/22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) certify (I) (we) right view the body after death.		22b. SIGNATURE Alan Chanales		DEGREE MD		22c. DATE SIGNED 9/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Alan Chanales, Md.		15225 Shady Grove Road, Rockville, MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Sept 2 1987		Beth David Cem.		Queens, New York	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ives-Pearson F. H. Falls Church, Va.		SEP 3 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

84-932 13740

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63644 AUG 25 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3780

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIE MCKINLEY BEATY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 13 1987		2b. HOUR 10:08 P M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 25 1935		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED TSGT		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIE MCKINLEY BEATY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLA THOMPSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1955-1975		17. INFORMANT ADDRESS ESTELLA WILLIAMS, 2555 ROSS ROAD, SILVER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACQUIRED IMMUNE DEFICIENCY SYNDROME DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 2 19 87 , to AUGUST 13 19 87 , that (I) (we) last saw the deceased alive on AUGUST 13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>D. E. Lewis</i>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 14 August 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. E. LEWIS, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 08-20-87	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington Co., VA	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS, INC., Silver Spring, MD		ADDRESS Silver Spring, MD		25a. DATE REC'D. BY REGISTRAR AUG 24 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician must be notified of the event.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

064438 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John H Beedle			2a. DATE OF DEATH MONTH DAY YEAR Aug 24 1987		2b. HOUR 6:50 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan 4 1895	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor	12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Montgomery	13d. CITY OR TOWN Brookeville	13e. STREET ADDRESS / ZIP CODE 19257 Treadway Road 20833
14. FATHER'S NAME FIRST MIDDLE LAST S. D. Beedle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not available		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 712 16 5814	17. INFORMANT Daughter Betty J. Roberts Same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Pulmonary Edema</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 19 <u>77</u> to <u>Aug 24</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>24 Aug</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr Lewis Kellert		22e. ADDRESS <u>4000 Olney Laytonsville Rd, Olney, MD 20832</u>			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Aug 29, 1987	23c. NAME OF CEMETERY OR CREMATORY Poplar Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		25a. DATE REC'D. BY REGISTRAR Aug 31 1987		25b. PLACE OF DEATH Rockville, Inc. 300 West Montg. Ave. Rockville, Maryland	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filled with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001438 SEP-1 85

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63360 AUG 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3782

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY N. BELLMAN SR.			2a. DATE OF DEATH MONTH DAY YEAR 8 13 87		2b. HOUR 10:50 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 5 5 47		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY FUEL CO.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY PRINCE GEORGE	13c. CITY OR TOWN LANDOVER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4215 72nd AVE 20784
14. FATHER'S NAME FIRST MIDDLE LAST Henry N. Bellman Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester S. Dalton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-46-1100		17. INFORMANT ADDRESS Charlotte Bellman Landover Hills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALCOHOLIC HEPATITIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ BETWEEN ONSET AND DEATH 10 WEEKS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/21 19 87 to 8/13 19 87 , that (I) (we) last saw the deceased alive on 8/12 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Michael Anchors MD				22c. DATE SIGNED 8/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. MICHAEL ANCHORS MD				22e. ADDRESS 9711 MEDICAL CENTER DR 103 ROCKVILLE MD 20850	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/17/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		
24. FUNERAL DIRECTOR NAME Rendon/Hale Lanham Fun'l Home		25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. ADDRESS 9013 Annapolis Rd. Lanham, Md. 20706					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062361 AUG 1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23 / 83

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ETHEL D. BELLMAR		AKA: BEHLMER		2. DATE OF DEATH MONTH DAY YEAR 8 4 87		3. HOUR 5:50 AM	
1. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 3, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. YES	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MD.		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15312 BASSWOOD CT. 20853	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DOUGHTY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH FLYNN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 136-20-6677		17. INFORMANT ADDRESS MR. GEORGE BEHLMER (SAME AS ITEM #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last: Chronic obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Obstructive Hemiparesis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 8/15/86 8/4 87			
22. I certify that (1) (this hospital) attended the deceased from 8/15/86 to 8/4 87 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above; (2) the doctor (did not) view the body after death.							
22a. SIGNATURE C.H. Lyon		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 8/4/87	
22c. PHYSICIAN'S NAME (Type or Print) C.H. Lyon		22d. ADDRESS 1841 Pr Philip Dr. Olney MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8-5-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. MD.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS SILVER SPRING, MD.		25. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Landale	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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063389 AUG 2 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23784
REG. NO.

FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Matthew			Charles	Bennefield	August			12, 1987	12:15 ^A
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White		May 23 1980		7		MONTHS		DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MICHIGAN		USA				Montgomery County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Bethesda		NIH, The Clinical Center									
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Michigan				Mount Clemens		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17023 N. Eleanor #110-A 48044			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
STEVEN		BENNEFIELD		MARY		(UNKNOWN)					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
NO				Mr. Steven Bennefield, father, same							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											HOURS
IMMEDIATE CAUSE (a) CARDIAC FAILURE											
DUE TO, OR AS A CONSEQUENCE OF											DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) MASSIVE GI HEMORRHAGE											
DUE TO, OR AS A CONSEQUENCE OF											YEARS
(c) ACUTE LYMPHOBLASTIC LEUKEMIA											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE							
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 2, 19 87, to August 12, 19 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 12, 19 87, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED			
Peter D. Aplan MD								8/12/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Peter D. Aplan MD		National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION					
REMOVAL		8/12/87		WUJER FUNERAL HOME		CITY OR TOWN COUNTY STATE					
						DETROIT MICHIGAN					
24 FUNERAL HOME OR NAME		4217 9TH ST. N.W.		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
MARSHALL'S FUNERAL HOME WASH, D.C.				AUG 18 1987		Julia Anderson-Randall					

003382 AUG 51 87

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063116 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23785
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GUSSIE, S. BERLIN			2a. DATE OF DEATH MONTH DAY YEAR 8-15-87		2b. HOUR 7:40 A		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03/02/1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 6121 Montrose Road		13f. STREET ADDRESS 20852					
14. FATHER'S NAME FIRST MIDDLE LAST Morris Seeman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Kostman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-62-2975		17. INFORMANT ADDRESS Esther Newman 4613 Cherry Vally Drive Rockville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) HYPERTENSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-3-85 , to 8-15-1987 , that (I) (we) last saw the deceased alive on 8-15-1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Loretto S. Albiol				22c. DEGREE MD		22d. DATE SIGNED 8-15-87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) LORETO S. ALBIOL				22f. ADDRESS 6121 MONTROSE RD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 17, 1987		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Maryland	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, Virginia				25. DATE REC'D. BY REGISTRAR AUG 18 1987			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

62956 AUG 17 87

FOR
- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b HOUR			
PABLO						BERMUDEZ		8		5		19		87				M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24 HOUR	
Male		Latin		Jan 15 1942		45 YRS.						August		8		7		1987		11:15 p	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH														MD.	
Panama		Panama						Montgomery County													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Takoma Park		9306 Roanoke Avenue		Caterer																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS													
Maryland		Montgomery		Takoma Park		YES		8306 Roanoke Ave													
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.		17. INFORMANT															
Wenseslao		Bermudez				Angela															
18. WAS DECEASED EVER (YES, NO, OR UNKNOWN)		18. WAS DECEASED EVER (YES, NO, OR UNKNOWN)		18. WAS DECEASED EVER (YES, NO, OR UNKNOWN)		18. WAS DECEASED EVER (YES, NO, OR UNKNOWN)															
no		no		no		no															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8-5- 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		Subject shot															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		9306 Roanoke Ave, Takoma Park, Mont.														MD.	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
death resulted from:		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy Chief		MEDICAL EXAMINER		DATE SIGNED		8/8/87													
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn St.		Balto.MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE															
Transit/Burial		8-17-87		Jardin De Paz		Panama City, Panama															
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Marshall Jones, Jr.		4101 Edmondson Ave		AUG 14 1987		Julia Gordon-Randall															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17
(VR A15 ME (5))

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Major John J. ...

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064092 AUG 28 1987
FOR REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3787
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AMY V. BLAIR			2a. DATE OF DEATH MONTH DAY YEAR 8/23/87		2b. HOUR 749 M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 6, 1896		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY SWITCHBOARD	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN HERBERT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE DEAN		13e. STREET ADDRESS / ZIP CODE 4011 RANDOLPH RD. 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-05-8625		17. INFORMANT ADDRESS MR. ALAN HERBERT 1743 LERCH FARM CT. DAVIDSONVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMATOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/13, 1985 to 8/22, 1987 , that (we) last saw the deceased alive on 8/23, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did not) view the body after death.							
22b. SIGNATURE Barry Rosenbaum, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY ROSENBAUM		22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8-24-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, Md. 20737		25. DATE REC'D. BY REGISTRAR AUG 27 1987		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to appropriate Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

BP

063907 AUG 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23788
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Fran Klin Blaszkiewicz		20. DATE KNOWN OF DEATH MONTH DAY YEAR Aug 20 1987		21. HOUR 8:30 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Oct 4 1939	6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS	7. UNDER 1 YR. MONTHS DAYS 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10. CITY OR TOWN OF DEATH Silver Spring 8800 Plaza Ave. Apt. 1		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REMODELING
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY BLASZKIEWICZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES BRYAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-38-5119		17. INFORMANT DAUGHTER ADDRESS 3801 EVANS TRAIL DONNA WILSON CT. BELTSVILLE, MD 20705
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30 P.M. 10 1987		
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Slip Ave Silver Spring Mont MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep		MEDICAL EXAMINER DATE SIGNED Aug 20 1987
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D.		ADDRESS 1919 SEMINARY ROAD SILVER SPRING, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE AUG 25, 1987	23c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION	23d. LOCATION CITY OR TOWN COUNTY STATE BURTONSVILLE MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR AUG 26 1987		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRAR

MARION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH3 7 8 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion M. BLATT		2a. DATE OF DEATH MONTH DAY YEAR 8 18 87		2b. HOUR 5:45 A.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 8 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS (LAST BIRTHDAY)) 91 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH SANDY SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FRIENDS NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OR SPECIFIC DUTY OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION			
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
13b. STREET ADDRESS / ZIP CODE 17340 QUAKER LANE 20860					
14. FATHER'S NAME FIRST MIDDLE LAST DAVID H. HEISTAND			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH A. SCHANTZ		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ***		16b. SOCIAL SECURITY NO. 175-40-4368		17. INFORMANT ELEANOR FERRIS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/17 , 19 83 , to 8/18 , 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 8/18 , 19 87 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check this box.)					
22b. SIGNATURE John G. Lodmell MD		DEGREE MD		22c. DATE SIGNED 8/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMELL MD		22e. ADDRESS 2901 Olney Rd. Olney Md 20832			
23a. BURIAL CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE AUG. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY BALT. WASH. CREMATORY	
23d. LOCATION LAUREL P. GEORGE		COUNTY MD.		STATE	
24. FUNERAL DIRECTOR MURIEL H. BARBER LAYTONSVILLE, MD. 20879				25. DATE RECORDED BY REGISTRAR AUG 20 1987	
25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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064499 SEP-28-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23790

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>FREDERICK BLUM</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 28 87</i>			2b. HOUR M <i>4:30</i>			
3. SEX <i>MALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 04 03</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>AUSTRIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MANAGER- RET.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RETAIL STORE</i>			
13a. STATE <i>MD.</i>			13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPR</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>ADOLF BLUM</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ADELE KRAUS</i>			16. SOCIAL SECURITY NO. <i>577-22-0567</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>577-22-0567</i>			17. INFORMANT <i>MRS. ELISE BLUM (wife) SILVER SPRING</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 year</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:									
19a. DATE OF OPERATION <i>13 August</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Bleeding - Ca of prostate</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>PM</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>PM 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/28 1979</i> , 19 <i>87</i> , to <i>August 28 19 1987</i> , that (I) (we) last saw the deceased alive on <i>8/28 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Joseph Bloom M.D.</i>				22c. DATE SIGNED <i>8/29/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph Bloom M.D.</i>				22e. ADDRESS <i>111 Spring St. Silver Spring, MD. 20910</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>8-30-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>JUDEAN MEM GDNS.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>OLNEY MD.</i>			
24. FUNERAL DIRECTOR <i>DANZANSKY-GOLDBERG MEM CHP INC</i>				25. DATE REC'D. BY REGISTRAR <i>SEP 1 - 1987</i>					
24. FUNERAL DIRECTOR <i>7770 ROCKVILLE PR. ROCKVILLE MD.</i>				25. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Russell L Bogley			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1987		2b. HOUR 10am M
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 26 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Messenger	12b. KIND OF BUSINESS OR INDUSTRY A.E.C.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 728 Grandin Avenue/20851	
14. FATHER'S NAME FIRST MIDDLE LAST Walter M. Bogley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie M. Ray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II	17. INFORMANT ADDRESS 14 Red Oak Road Lillie Belle Baker, Hilton Head Is. S.C. 29928		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lymphoma-anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>G.I. Bleeding</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 years 3 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) did not attended the deceased from <u>March 6, 1984</u> , to <u>August 31, 1997</u> , that (I) last saw the deceased alive on <u>August 3, 1987</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.					
22b. SIGNATURE <i>Frauke Westphal</i>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED August 31, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.		22e. ADDRESS 809 Viers Mill Road, Rockville, Md. 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home- Rockville, Inc. 300 W. Montgomery Av., Rockville, Maryland 20850			25a. DATE REC'D BY REGISTRAR SEP 8 1987		
			25b. REGISTRAR'S SIGNATURE <i>Alia Robinson-Randall</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

BP

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Barbara Ann Bolton		2a. DATE OF DEATH 7 21 87		2b. HOUR 0100	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/18/30	
6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. UNDER 24 HRS HOURS 0 MIN 0	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? USA		9c. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takeville Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION Retired Secretary	
12b. KIND OF BUSINESS OR PROFESSION Plumbing Co.		13a. STATE MD		13b. COUNTY Montgomery	
13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5900 Oxford Rd 20812	
14. FATHER'S NAME FIRST Charles MIDDLE Leon LAST Phillips		15. MOTHER'S MAIDEN NAME Marie Estelle Schneider		16. ADDRESS 24133 Pecan Grove Ln Gaithersburg, Md. 20879	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214 289 254		17. INFORMANT Donna A. Arnold (daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock Perforated Viscus DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Ca DUE TO, OR AS A CONSEQUENCE OF (c) Small Cell Ca Lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 8 MO.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Mets Brain, Breast Left ABCentral					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-17-87 , 19____, to 7-21-87 , 19____, that (I) (we) lost saw the deceased alive on 7-20-87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W.D. Ferguson		22c. DEGREE MD		22d. DATE SIGNED 7-21-87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) W.D. Ferguson		22f. ADDRESS 4701 Randolph Rd Mont MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/23/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	
23d. LOCATION CITY OR TOWN Rockville, Maryland		23e. STATE MD		23f. ZIP CODE 20852	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		24a. ADDRESS 1331 Rockville Pike, Rockville, Md. 20852		24b. DATE REC'D. BY REGISTRAR JUL 24 1987	
24c. REGISTRAR'S SIGNATURE Julia Fisher-Randall		24d. REGISTRAR'S NAME Julia Fisher-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

060717 JUL 25 87

JUL 24 1987

062362 AUG 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23794
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul L Borner			2a. DATE OF DEATH MONTH DAY YEAR August 6 1987		2b. HOUR 445 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1922		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker (Ret.)			12b. KIND OF BUSINESS OR INDUSTRY Real Estate			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 7505 Democracy Blvd., #A224; (20817)						
14. FATHER'S NAME FIRST MIDDLE LAST David Borner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Levy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-20-9331		17. INFORMANT #A224, Bethesda, Md. 20817 Marjorie L. Borner; Wife; 7505 Democracy Blvd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardia Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of The Bile Ducts DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-1-87 to 8-6-87 , that (I) examined saw the deceased alive on 8-6-87 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.						
22b. SIGNATURE John Tauber		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-6-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS Bethesda Md. 8218 Wisconsin Ave				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/9/87		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		
23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.		24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852				
25a. DATE REC'D. BY REGISTRAR AUG 10-1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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062298 AUG 11 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Patricia F. Bowser			2a. DATE OF DEATH MONTH DAY YEAR August 5, 1987		2b. HOUR 8:00 P.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7, 1922		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fl		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 65		
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 442 Girard Ave.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative Asst.		12b. KIND OF BUSINESS OR INDUSTRY Mont. Co.		12c. DATE OF DEATH Gov't.		
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST John Farnsworth		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Kubel		13d. STREET ADDRESS / ZIP CODE 442 Girard Ave. 20877		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-24-3753		17. INFORMANT ADDRESS William R. Bowser 6913 Westmoreland Ave. Takoma Pk, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA TO BRAIN DUE TO, OR AS A CONSEQUENCE OF (c) WAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): WAS						
19a. DATE OF OPERATION 8/5/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 8/5/87		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/5/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 8/5/87		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8/5/87		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/5/87		
22a. I certify that (I) (this hospital) attended the deceased from 8/5/87 to 8/5/87 , that (I) (we) saw the deceased alive on 8/5/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Carol Margolis, M.D.		DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 8/6/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol Margolis, M.D.		22e. ADDRESS 11404 Old Georgetown Rd., Rockville MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/87		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Wash., DC		23e. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23f. LOCATION CITY OR TOWN COUNTY STATE Wash., DC		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR AUG 10 1987		
25b. REGISTERED SIGNATURE John Farnsworth				25c. DATE REC'D. BY REGISTRAR AUG 10 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. The funeral director must remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

062238 AUG 11 87

8:00 P.

August 2, 1987

Female	White	May 7, 1925	62
U.S.A.	x	Montgomery	
442 Girard Ave.	Administrative Asst. Gov't.	Mont. Co.	
Mont.	442 Girard Ave.	x	
John	Fairsworth	Florence	
No	570-04-3287	William R. Bowser 6013 Westmoreland Ave.	

Joseph Gwiler's Sons, Inc.
5100 N. Ave. NW Wash., DC 20016
8/8/87
St. Mary's Cem.
Wash., DC

065024 SEP -9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23790

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine F. Bradley			2a. DATE OF DEATH MONTH DAY YEAR 8 31 87			2b. HOUR 2:35 ^{PM}	
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 8 31 04	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN) Pennsylvania	7c. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10. CITY OR TOWN OF DEATH Olney, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brook Grove		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Olney	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 17820 Buehler Road/20832			
14. FATHER'S NAME FIRST MIDDLE LAST Francis Bradley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Jordan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 197-05-0265		17. INFORMANT ADDRESS 1 West Belair Road Ridley Park, PA 19078			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Shuntles</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 mo.</u> DUE TO, OR AS A CONSEQUENCE OF <u>Organic Brain Syndrome</u> (c) <u>ye</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Brain Hernia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		21d. DATE SIGNED 8/31/87	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/18/87</u> to <u>8/31/87</u> , that (I) (we) last saw the deceased alive on <u>8/18/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. [Signature]		22e. ADDRESS 1811 P. Philip Dr Olney, MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 4, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Denis Cemetery		23d. LOCATION Havertown, Pennsylvania	
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda-Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814				25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE Julia [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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SEP 8 1981

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AUG 25 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23797
REG. NO.

2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
8			18			87		
418						P.M.		
3 SEX			4 RACE			5 DATE OF BIRTH		
MALE			White			5 19 20		
6 AGE (IN YEARS LAST BIRTHDAY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
67			U.S.A.					
9 BALTIMORE CITY OR COUNTY OF DEATH			10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		
Montgomery County, MD.			N.Y. U.S.A.			Holy Cross Hosp.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS?		
Senate Staff (Ret.) U.S. Gov't.						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13b. STREET ADDRESS / ZIP CODE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
(20853) 14212 Chadwick Ln.			Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Isadore Breger			Ethel Wexler			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
057-12-7332			Muriel Breger; Wife;			Rockville, Md. 20853		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) hepatic, renal failure			7d					
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
b) metastatic carcinoma liver								
DUE TO, OR AS A CONSEQUENCE OF								
c) Carcinoma pancreas								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
8-10-87			obstructive jaundice			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS CAUSING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8-6 1987, to 8-18 1987, that (I) (we) lost saw the deceased alive on 8-18 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Ira N. Brecher MD						8-18-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE REC'D. BY REGISTRAR		
IRA N. BRECHER, MD			2101 Medical Park Dr Silver Spring, Md. 20902			AUG 24 1987		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			8/20/87			Judean Memorial Gdns.; Olney; Montgomery; Md.		
24 FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852			AUG 24 1987			[Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or other qualified person within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use at the burial or cremation. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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063010 AUG 18 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 7 9 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Frank K		MIDDLE LEE		LAST Bridges		2a. DATE OF DEATH MONTH DAY YEAR 8-7-87		2b. HOUR 12 A M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 05 10		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital of Sil Spr						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Currie Lee Bridges						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 185-03-3343		17. INFORMANT 1703 Crestview Drive Opal Rucker/Potomac, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>decubitus ulcers</u> (c) <u>atherosclerotic vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from <u>MAY</u> 19 <u>87</u> to <u>7 AUG</u> 19 <u>87</u> , that (I) last saw the deceased alive on <u>6 AUG</u> 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did not</u> view the body after death.											
22b. SIGNATURE <u>Walter Gooch MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7 Aug 87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER GOOCH MD</u>						22e. ADDRESS <u>8709 SHOREFIELD RD WHEATON MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-10-87		23c. NAME OF CEMETERY OR CREMATORY Georgetown Med School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services						25a. DATE REC'D. BY REGISTRAR AUG 17 1987		25b. REGISTRAR'S SIGNATURE <u>A. B. Henderson-Randall</u>			
225 Missouri Ave, NW Washington, DC 20011											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

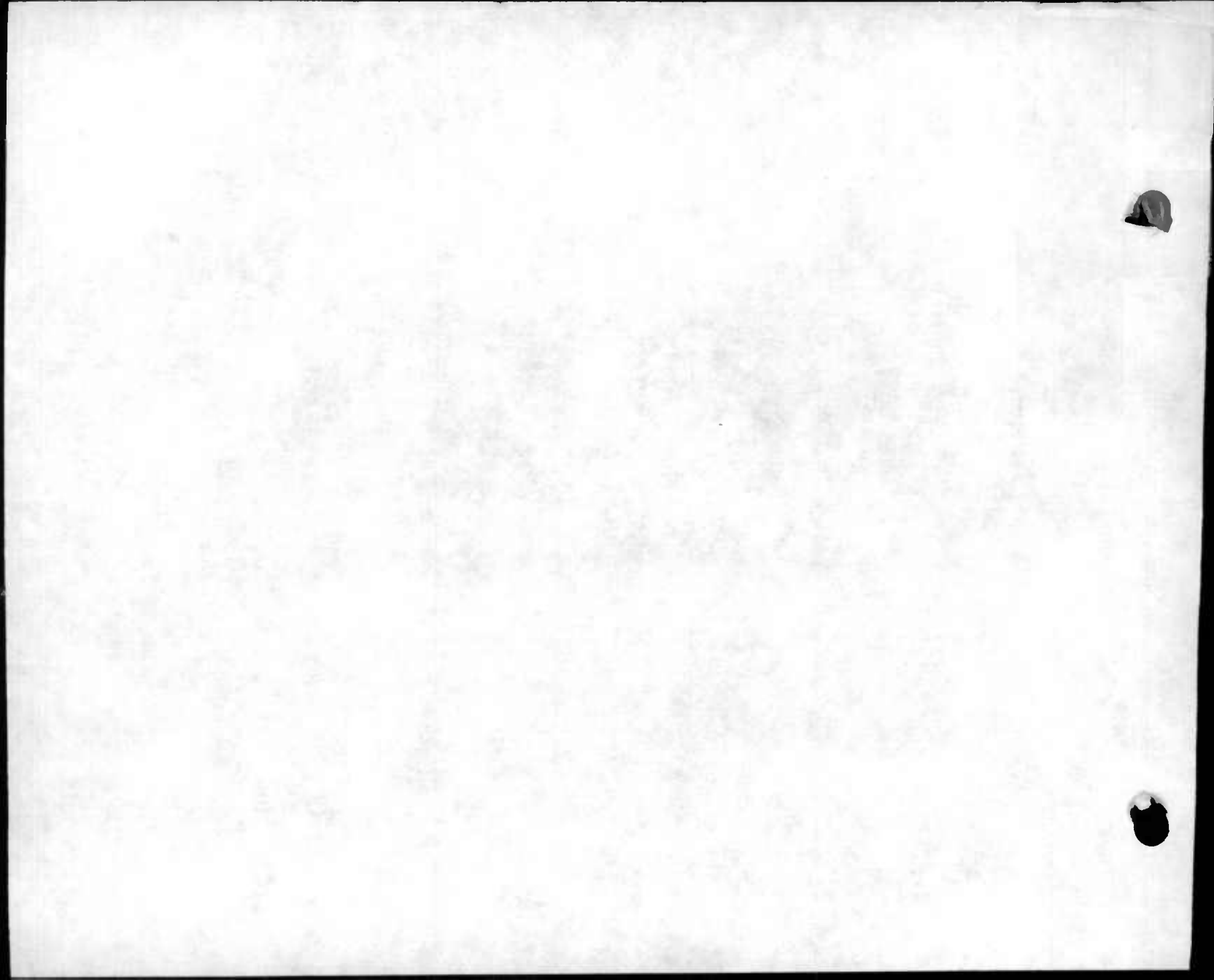
BP

083010 AUG 19 84

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Void Death Certificate #87-23799



063941 AUG 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 0 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Phoebe Matilda Burtnett</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 24 87</i>		2b. HOUR <i>0510 M</i>
3. SEX <i>FEMALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 17-1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Reg. Nurse</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Montg.</i>	13c. CITY OR TOWN <i>Takoma Park</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>8205-Flower Ave Apt #1 20912</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Mary</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pearl</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR DATES) <i>217-32-1999</i>		17. INFORMANT ADDRESS <i>Sylvia Woodcock 13e.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atrial Fibrill</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5+ yrs</i> <i>5+ yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>CVA Dehydration car inacc hypothyroid Renal failure</i>					
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>— P.M. — 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <i>—</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>—</i>	
22a. I certify that (1) (this hospital) attended the deceased from <i>3</i> 19 <i>78</i> , to <i>8-24</i> 19 <i>87</i> , that (1) (we) lost saw the deceased alive on <i>8-23</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>R.H. Sandstrom MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8-24-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R.H. Sandstrom MD</i>		22e. ADDRESS <i>7701 CARROLL AVE TAKOMA PARK MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug 26-1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	
24. FUNERAL DIRECTOR NAME <i>Thomas F. Wilson</i>		ADDRESS <i>254 Carroll St. NW, 20012</i>		25. DATE REC'D. BY REGISTRAR <i>AUG 26 1987</i>	
25. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		26. REGISTRAR'S SIGNATURE <i>—</i>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

003041 AUG 23 81

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Handwritten notes and signatures, including a large signature at the bottom center and several lines of text above it.

AUG 23 81

063386 AUG 21 87

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 8-15-87			MONTH DAY YEAR			2b HOUR		
3 SEX Male			4 RACE Black			5 DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1969 17 YRS.			6 AGE (IN YEARS) (LAST BIRTHDAY)			7c IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			2d DATE PRONOUNCED DEAD 8-15-87 9:26a		
10 CITY OR TOWN OF DEATH Takoma Pk.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student			12b KIND OF BUSINESS OR INDUSTRY					
13a STATE MD			13b CITY OR TOWN Pr. Geo. Beltsville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 13322 Evans Trail #3/ 20705					
14 FATHER'S NAME FIRST MIDDLE LAST George T. Burton, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine D. Cooper			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b SOCIAL SECURITY NO. 220-80-9002			17. INFORMANT ADDRESS George Burton, Sr. (father) same as #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Mario F. Golle, Jr.</i>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 8-16-87								
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D.			ADDRESS 111 Penn Street											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 8-20-87			23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg, MD					
24 FUNERAL DIRECTOR NAME George R. Snowden			ADDRESS Rockville, MD 20850			25a DATE REC'D. BY REGISTRAR AUG 19 1987			25b REGISTRAR'S SIGNATURE <i>Barbara R. Rindall</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 REG. NO. 2

1- STATE REGISTRAR
DECEASED NAME FIRST MIDDLE LAST
MICHAEL CADE

2a. DATE KNOWN OF DEATH MONTH DAY YEAR
8 29 87 **P** **M**

3. SEX **Male** **4. RACE** **White** **5. DATE OF BIRTH** MONTH DAY YEAR
05 01 66 **6. AGE (IN YEARS)** **21** **IF UNDER 1 YR** MONTHS DAYS HOURS MIN
7c. DATE PRONOUNCED DEAD MONTH DAY YEAR
9 1 87 **09 31** **M**

7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Mass.** **7b. CITIZEN OF WHAT COUNTRY?** **USA** **8. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐ **9. BALTIMORE CITY OR COUNTY OF DEATH** **MONTGOMERY** **MD.**

10. CITY OR TOWN OF DEATH **LAYTONSVILLE** **11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)** **ROUTE 108 YESTERYEAR FARM** **12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)** **Plumbers Helper** **12b. KIND OF BUSINESS** **Shelly Plumbing, Inc.**

13a. STATE **MD** **13b. COUNTY** **MONTGOMERY** **13c. CITY OR TOWN** **LAYTONSVILLE** **13d. INSIDE CITY LIMITS?** **YES** ☐ **NO** ☒ **13e. STREET ADDRESS** **YESTERYEAR FARM ROUTE 108**

14. FATHER'S NAME FIRST MIDDLE LAST **George H. Cade** **15. MOTHER'S MAIDEN NAME** FIRST MIDDLE LAST **Judith Ann Barrett**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No** **16b. SOCIAL SECURITY NO.** **108-56-4866** **17. INFORMANT** **Geo. H. Cade (father)** **ADDRESS** **Rd 2 Box 150 Cooperstown, N.Y. 13326**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **ASPHYXIA**
DU TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) **DEPRESSION**
DU TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ACUTE
INDEF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION **19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?** **20. AUTOPSY?** **YES** ☐ **NO** ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH **21b. TIME OF INJURY** HOUR A.M. MONTH DAY YEAR
PM P.M. 8 29 19 87 **21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)** **Hose From EXHAUST INTO CAR**

21d. INJURY OCCURRED **21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)** **21f. LOCATION** STREET CITY OR TOWN COUNTY STATE
WHILE ☐ NOT WHILE ☒ AT WORK ☐ AT WORK **FARM** **YESTERYEAR FARM ROUTE 108 LAYTONSVILLE** **MONT MD**

22a. I certify that I took charge of the remains described above, held on death resulted from: **Natural causes** ☐ **Accident** ☐ **Suicide** ☒ **Homicide** ☐ **Undetermined manner** ☐ **Autopsy** ☐ **Inspection** ☒ **Inquiry** ☒ **and in my opinion**

ACTUAL SIGNATURE **Francis C. Mayle** **TITLE (SPECIFY)** **DEPT** **M.D.** **DATE SIGNED** **9/1/87**

EXAMINER'S NAME (TYPE OR PRINT) **FRANCIS C MAYLE** **ADDRESS** **8200 Wisconsin Ave Bethesda MD**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** **23b. DATE** **9/4/87** **23c. NAME OF CEMETERY OR CREMATORY** **Fly Creek Cemetery** **23d. LOCATION** CITY OR TOWN COUNTY STATE
Fly Creek, New York

24. FUNERAL DIRECTOR **Tyson Wheeler Funeral Home, Inc.** **25a. DATE REC'D. BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE**
1331 Rockville Pike, Rockville, Md. 20852 **SEP 10 1987** **Julia Davidson-Randall**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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RECEIVED
MAY 17 1961
FBI - NEW YORK

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63459 AUG 21 1987

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23803
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Richard		Patel		Callahan				5		8		14-87 0338AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		Dec. 8, 1918		68		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Ohio		USA		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Montgomery						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Takoma Park		Washington Adventist Hospital		maintenance		Laurel Race							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md		P G		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		42 B Avondale Street		20707			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Joseph N. Callahan		Bess L. Ward		yes		268 14 5670		June Barnes		908 White Way, Laurel, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a)		respiratory failure		DUE TO, OR AS A CONSEQUENCE OF		(b)		metastatic cancer in lung		DUE TO, OR AS A CONSEQUENCE OF		(c)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from		June 8, 1987		to		Aug 8, 1987		that (I) (we) last saw the deceased alive on		8/13		1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Martin S. Kelly						8/14/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
MARTIN WELTZ		1525 Greenway Cr Pine Greenbelt MD 20710											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Aug 17, 1987		Ivy Hill Cemetery		Laurel, Md							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Donaldson Funeral Home, Laurel, Md				AUG 19 1987		Julia Davidson-Randall							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other, traumatic event, the medical examiner must be notified and advised.

Film G631 item 7 9/1/87 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Domenic BRUNO			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 21 1987			2b. HOUR 405 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
12. CITY OR TOWN OF DEATH S.S.		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		15. KIND OF BUSINESS OR INDUSTRY Retired			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 500 Gilmore Drive 20901	
17. FATHER'S NAME FIRST MIDDLE LAST Anthony Bruno		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nina Navaria		19. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A					
16b. SOCIAL SECURITY NO. 579 01 4315A		17. INFORMANT ADDRESS Agatha Bruno (Wife) Same as 13E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure, Pleural Effusion									
19a. DATE OF OPERATION 8/19/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pleural Effusion		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 19, 1987 , to August 21, 1987 , that (I) (last) saw the deceased alive on August 21, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Barry Hecht		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/21/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Hecht		22e. ADDRESS 3941 PENNARA DRIVE WHEATON, MD 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Maryland			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp Ave. S.S.Md		25a. DATE REC'D. BY REGISTRAR AUG 25 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall					

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

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U.S. DEPT. OF AGRICULTURE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA LOUISE CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR 8-6-87			2b. HOUR 0047 ^M			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY CAMPBELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA CAMPBELL			16. STREET ADDRESS / ZIP CODE 1261 First St. / 20850			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-38-267		17. INFORMANT ADDRESS Joyce Williams (daughter) 1072 Good Hope Dr. S. Spring. 20904				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Respiratory Distress Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia and Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>87</u> to <u>8.5.87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8.5</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John E. Kelly			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8.6.87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Kelly			22e. ADDRESS 9715 Medical Center Dr						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-11-87		23c. NAME OF CEMETERY OR CREMATORY Pleasant View Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. MD		
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. Washington St. Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE A. J. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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064403 SEP-187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23806

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY G LAST CAMPBELL			2a. DATE OF DEATH MONTH DAY YEAR 8 27 87			2b. HOUR 6:20 PM				
3. SEX FEMALE		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR May 13, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9306 FERNWOOD ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH S SCHULTZ					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY FAMOUS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 291-18-4638		17. INFORMANT ADDRESS BETHESDA, MARYLAND JERRY L HINZMAN 9306 FERNWOOD RD (20818)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR OCCLUSIONS 2 days DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ATHEROSCLEROSIS 5 YEARS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE; POLYMYALGIA RHEUMATICA										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from August 21 19 87, to August 27 19 87, that (I) (we) last saw the deceased alive on August 21 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Henry Roth MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug 27, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY ROTH, MD				22e. ADDRESS 8218 WISCONSIN AVE, BETHESDA, MD						
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 8/28/87		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON DC				
24. FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA				25a. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH 16 60M 1/73

(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE 11/11/85
TIME 14:00
MOBILE

064413 SEP -

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23807

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VICTOR G. CANTIZANO			2a. DATE OF DEATH MONTH DAY YEAR 08-23-87			2b. HOUR 6:17 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dominican Rep.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b. KIND OF BUSINESS OR INDUSTRY Radiology	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Humberto Cantizano				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Arias					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 581 90 8323		17. INFORMANT Son Robert D. Cantizano ADDRESS 4319 Ellicott St. Washington DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 mins 12 hrs 2 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from AUG. 23, 1987 to AUG. 23, 1987 , that (I) (we) last saw the deceased alive on AUG. 23, 1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas G. Sinderson, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD				22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Montgomery Crematorium Bethesda, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Bethesda Chevy Chase Inc. 7557 Wisconsin Ave Bethesda MD				25a. DATE REC'D. BY REGISTRAR AUG 31 1987					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

06413 SEP-187

AUG 31 1871

063339 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		A	
GERARD		T.		CAWLEY	AUGUST 14, 1987					2:18		M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.				
Male	Caucasian		November 2, 1920		66		MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Pennsylvania	USA				Montgomery						MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Rockville	14112 Castaway Drive		Management Analyst V.A.										
13a. STATE				13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS						
Maryland				Montgomery	Rockville	YES <input type="checkbox"/> NO <input type="checkbox"/>	14112 Castaway Drive		20853				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
John				Louise									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes				WW II		165-18-7238		Ruth M. Cawley		Wife		Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral 176 Invas</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13/87</u> to <u>8/14/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Allan B. Cohan, M.D., P.A.										8-17-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Allan B. Cohan, M.D., P.A.				13975 Conn. Ave., Sil. Sp., MD20906									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Cremation				Aug. 18, 1987		Metropolitan Crematory		Alexandria		Virginia			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Francis J. Collins, Jr.				AUG 20 1987									
500 University Blvd., W. Silver Spring, Md. 20906													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or, item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

003330 AUG 51 81

7/6

1040000

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063908 AUG 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 8 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rita B. Chaconas			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1987		2b. HOUR 2:00 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 21, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Early M. Blankenbaker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Aylor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 577-03-4667		17. INFORMANT ADDRESS Wilhelmina P. Blankenbaker same as #13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Age & General Debility</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's disease</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>11c</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July</u> , 19 <u>83</u> , to <u>August 20</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 20</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>CM Benner MD</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED August 20, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M. Benner, M.D.		22e. ADDRESS 11161 New Hampshire Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 24, 1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland	
24. FUNERAL DIRECTOR Robert A. Humphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland 20850				25. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE <u>John Darden</u>	

MEDICAL CERTIFICATION

3

9

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

083308 V06 55 81



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Dolores Marie Chase								8/13		19		87				M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Black	Oct. 2, 1927		59 YRS.						8/13		19		87		P. 1:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NORTH CAROLINA		UNITED STATES				Montgomery County MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		3007 Hewitt Avenue, #426		CROSSING GUARD		PUBLIC SCH											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS									
Maryland		Montgomery		Silver Spring				3007 Hewitt Avenue, #426									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
ROSSIE M. GRAVES		PARTHENIA GRIFFIN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		3007 Hewitt									
NO		577381082		WILLIE McGRUFF (SON)		#426 SS.Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Metastatic carcinoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				(b)		carcinoma of the right breast.		6 weeks									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
None		P.M. 19		None													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED		8/14/87									
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.		1919 Seminary Road		Silver Spring, Montgomery County, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		8/21/87		LINCOLN MEMORIAL		SUTTLAND P.G. MD											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Hunt F.H..		2801 7th St. N.E.		AUG 31 1987		Julia Burden-Roberts											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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Chase

Marie

Dolores

1:50

873

29

Oct. 2, 1927

Black

Female

Montgomery County

3007 Hewitt Avenue, W-26

Silver Spring

3007 Hewitt Avenue, W-26

Silver Spring

Montgomery

Maryland

Metastatic carcinoma

6 weeks

carcinoma of the right breast.

None

None

None

x

x

8/1/67

Deputy

1019 Seminary Road

Silver Spring, Montgomery County, MD

John G. Rogers, M.D.

AUG 31 1967

W.H.M.

062859 AUG 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLIFFORD G. CLAGGETT			2a. DATE OF DEATH MONTH DAY YEAR 8 3 87		2b. HOUR 10 35 PM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Mar 3, 1935	6. AGE (IN YEARS (LAST BIRTHDAY)) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montg.	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Howard Claggett			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean Mitchell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-34-2059		17. INFORMANT ADDRESS JOHN Claggett (Brother) SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prostatic Tonsillar Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>February</u> 19 <u>87</u> , to <u>Aug 3</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>Aug 3</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>8/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph V. Bocca		22e. ADDRESS 14800 Physicians Ln #271 Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-8-87	23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville, Montg. MD	
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville, Md 20850		25a. DATE REC'D. BY REGISTRAR AUG 12 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

005822 AUG 15 05

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 1 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth W. Clark			2a. DATE OF DEATH MONTH DAY YEAR August 13, 1987		2b. HOUR A 3:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 24, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13600 North Gate Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Furniture Co.
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST George Willhide			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia (Unavailable)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-20-4098		17. INFORMANT Brady M. Clark, Same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u>		<u>1 yr</u>
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a <u>Carcinoma of the Ovary</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>November 29</u> , 19 <u>83</u> , to <u>August 13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Daniel J. Boyle</u>				22c. DATE SIGNED August 13, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel J. Boyle, M. D.				22e. ADDRESS 10313 Georgia Avenue, #201 Silver Spring, MD 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-13-87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc.		25a. DATE REC'D. BY REGISTRAR AUG 18 1987	
P. O. Box 43352, Washington, DC 20010		25b. REGISTRAR'S SIGNATURE <u>Julia K. Rapp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 should show any injury, or other traumatic event, that would constitute a reportable event.

BP

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063906

AUG 27 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6813

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2c. DATE OF DEATH		MONTH		DAY		YEAR					
Albert J. Clarke								Aug 21 1987								Aug 21 1987											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		7d. DATE OF DEATH		MONTH		DAY		YEAR	
M		W		DEC 23, 1898		88 YRS						Aug 21 1987								Aug 21 1987							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																			
VIRGINIA		USA						Montgomery																			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																					
Sil. Spg		2318 Hermitage Ave		KEYBOARD OPERATOR		GPO																					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																			
MD		Mont.		Sil. Spg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2318 Hermitage Ave																			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																									
JOHN		AGNES PARKER																									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																					
YES		1918-1919		579-22-6183		DAUGHTER		2740 NW 106TH																			
						DOROTHY C. VECHERY		AVE. CORAL SPRINGS,																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		FLA. 33065		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
				Acute Myocardial Dis																							
				Chronic Myocardial Dis + Emphysema																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
None																											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																							
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
		HOUR A.M. MONTH DAY YEAR																									
		P.M. 19																									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED																					
John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Md.																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																					
BURIAL		AUG 25, 1987		FT. LINCOLN		BRENTWOOD PRINCE GEORGES MD																					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																			
FRANCIS J. COLLINS, JR.		500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901				AUG 26 1987																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR PAGE 3. BEHAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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W/TH 11/11



AUG 55 91

063342 AUG 2

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 1 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGUERITE B. CLEARY			2a. DATE OF DEATH MONTH 8 DAY 10 YEAR 87		2b. HOUR 7:23 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 9 DAY 21 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES REP		12b. KIND OF BUSINESS OR INDUSTRY HECHT CO.
13a. STATE MD			13b. COUNTY MONT.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST JOSEPH MIDDLE BOSCO LAST BOSCO			15. MOTHER'S MAIDEN NAME FIRST HENRIETTA MIDDLE SEVENHUYSEN LAST SEVENHUYSEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-03-7620		17. INFORMANT DAUGHTER ADDRESS P.O. BOX 9 KATHLEEN C. BERGLING CLEMENTS, MD 20624	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive CVA (Stroke) DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral embolism DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Bluing lesion					
19a. DATE OF OPERATION 8/7/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED emboli to Brain + Leg.		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/5 , 19 87 , to 8/10 , 19 87 , that (I) (we) last saw the deceased alive on 8/10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Louis Kozloff				22c. DATE SIGNED 8/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Kozloff, M.D.		22e. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 14, 1987	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGES MD
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901				25a. DATE REC'D. BY REGISTRAR AUG 20 1987	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23815

REG. NO.

DECEASED NAME (TYPE OR PRINT) John Angelo Cocumelli		2b. DATE OF DEATH MONTH 8 DAY 27 YEAR 1987		2b. HOUR 12:02 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH March DAY 5 YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY City of Steubenville
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Ohio 13b. COUNTY Jefferson 13c. CITY OR TOWN Steubenville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3267 Sunset Blvd. 43952	
14. FATHER'S NAME FIRST John MIDDLE A. LAST Cocumelli		15. MOTHER'S MAIDEN NAME FIRST Philomena MIDDLE Morelli LAST Morelli			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 268-16-9095		17. INFORMANT ADDRESS Lucille Cocumelli, Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/24 19 87 to 8/27 19 87 , that (I) (we) lost saw the deceased alive on 8/24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard Goldberg		DEGREE MD		22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Goldberg		22e. ADDRESS 12012 Veers Mill Rd Wheeling MD 26050			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-31-87		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery	
				23d. LOCATION CITY OR TOWN Steubenville, Ohio COUNTY STATE	
24. FUNERAL DIRECTOR NAME Mosti Funeral Home ADDRESS 321 South 4th Street, Steubenville, OH 43952		25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 31 1987 John Burden-Randall			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove these papers, Pages 1 and 2, and file them within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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SEP 31 1961

063040 4 AUG 1987

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence M. COHALL			2a. DATE OF DEATH MONTH DAY YEAR Aug 5 1987			2b. HOUR 11⁴⁹ AM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 1-28-23		6. AGE (IN YEARS LAST BIRTHDAY) 64 y.o.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jamaica		7b. CITIZEN OF WHAT COUNTRY? Jamaica		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY Prince George's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Walters		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A					
16b. SOCIAL SECURITY NO. 578-82-3742		17. INFORMANT ADDRESS Elaine Blackwood 5300 Criffenden St. Riverdale Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Stem Stroke DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes Mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 Aug 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 1111 Kennedy Highway Ave SE, DC 20003					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1111 Kennedy Highway Ave SE, DC 20003		22a. I certify that (I) (this hospital) attended the deceased from 2 Aug 87 to 5 Aug 87 that (we) lost 1111 Kennedy Highway Ave SE, DC 20003 saw the deceased alive only above (I) (we) (did) (did not) see the body after death.			
22b. SIGNATURE Michael Leibowitz MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5 Aug 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz MD		22e. ADDRESS 1111 Kennedy Highway Ave SE, DC 20003							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/10/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md.			
24. FUNERAL DIRECTOR NAME R.N. Horton Co. Inc.		ADDRESS 600 Kennedy St. D.C. 20011		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 14 1987					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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064556 SEP 2 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2a DATE OF DEATH MONTH DAY YEAR
AUGUST 26, 1987 3:00 A.M.DECEASED NAME FIRST MIDDLE LAST
ANNA COHEN3 SEX
FEMALE4 RACE
WHITE5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 25, 18986 AGE (IN YEARS LAST BIRTHDAY)
88 YRS.IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN)
POLAND7b. CITIZEN OF WHAT COUNTRY?
POLAND8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD.10. CITY OR TOWN OF DEATH
WHEATON11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY CONVALESCENT & NURSING HOME12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS12b. KIND OF BUSINESS OR INDUSTRY
CLOTHINGUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND13b. COUNTY
MONTGOMERY13c. CITY OR TOWN
SILVER SPRING13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS / ZIP CODE
14508 HOMECREST ROAD 2090614 FATHER'S NAME
FIRST MIDDLE LAST
ABRAM GREENBERG15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LENA (UNASCERTAINABLE)16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(IF YES, GIVE WAR OR DATES)
NO16b. SOCIAL SECURITY NO.
124-14-322817 INFORMANT
12820 CAMELLIA DRIVE
KENNETH J. COHEN, SILVER SPRING, MARYLAND18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebrovascular accident

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 hrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from 8/15/87, 1987, to 8/25/87, 1987, that (I) (we) lost
saw the deceased alive on 8/25/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did (did not) view the body after death.22b. SIGNATURE
Myron L. LenkinDEGREE
ATTENDING ☒ MEDICAL ☐ STAFF
PHYSICIAN DIRECTOR PHYSICIAN22c. DATE SIGNED
8/25/8722d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. MYRON L. LENKIN, M. D.22e. ADDRESS
2309 SHOREFIELD ROAD
SILVER SPRING, MARYLAND23a. BURIAL, CREMATION, REMOVAL
BURIAL23b. DATE
8/27/198723c. NAME OF CEMETERY OR CREMATORY
JUDEAN MEMORIAL GARDENS23d. LOCATION
CITY OR TOWN COUNTY STATE
OLNEY, MONTGOMERY, MARYLAND24 FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C.25a. DATE REC'D. BY REGISTRAR
AUG 28 198725b. REGISTRAR'S SIGNATURE
Lisa Davidson-RudackTO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the duplicate pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.
IMPORTANT: If item 21 is marked as having been any injury, or other traumatic event, the medical examiner must be notified at once.

064229 SEP-50

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064424 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 0 1 8
1. DECEASED NAME (TYPE OR PRINT) SARA COTTON 2a. DATE OF DEATH MONTH 8/26 DAY 27 YEAR 1105A M.3. SEX FEMALE 4. RACE CAUCASIAN 5. DATE OF BIRTH MONTH 9 DAY 25 YEAR 1901 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.10. CITY OR TOWN OF DEATH SILVER SPRING 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER 12b. KIND OF BUSINESS OR INDUSTRY HOMEUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SSPG. 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 1220 BLAIR MILL RD. 2091014. FATHER'S NAME FIRST NATHAN MIDDLE LAST WILK 15. MOTHER'S MAIDEN NAME FIRST EDITH MIDDLE LAST (UNKNOWN)16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) NONE 16b. SOCIAL SECURITY NO. 213-74-2483 17. INFORMANT ADDRESS 1051 SAXONY DR. HIGHLAND PARK MR. MICHAEL CAHR (son) TLL18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic shock
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 24hrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/18 19 86 to 8/26 19 86 that (I) (we) lost the deceased alive or above, (I) (we) (did) (did not) view the body after death. 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated22a. SIGNATURE Penny Bisk DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 8/26/8622d. PHYSICIAN'S NAME (TYPE OF PRINT) PENNY BISK 22e. ADDRESS 18313 Gloria Ave Beltsville23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 8-28-87 23c. NAME OF CEMETERY OR CREMATORY SHARON GARDENS 23d. LOCATION CITY OR TOWN COUNTY STATE VAIHALIA N.Y.24. FUNERAL DIRECTOR DAN LANSKY-GOLDBERG MEM. CHP INC. 1170 ROCKVILLE PK. ROCKVILLE MD. 25a. DATE REC'D. BY REGISTRAR AUG 31 1987 25b. REGISTRAR'S SIGNATURE Julia Gordon-Robert

DIVISION OF VITAL RECORDS, 201 W. PEESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner will be notified of same.

BP

0844 SEP-18

AUG 21 1981

063024 AUG 8 87

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harvey Daniel Cole, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 8/12/87		2b. HOUR 1140 AM								
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Electronics					
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19 North Summit Ave., 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Daniel Cole, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joyce Hackett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes				16b. SOCIAL SECURITY NO. 220 58 6692		17. INFORMANT ADDRESS Reston, Va. 22091 Harvey D. Cole, Sr., 11010 Thrush Ridge Rd.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System collapse</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acquired Immune Deficiency Syndrome</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 YR.</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>1 YR.</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>86</u> , to <u>Aug. 12</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Aug 11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Frank J. Mayo</u>						DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-12-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK J. MAYO						22e. ADDRESS 16220 FRIEDRICK RD. # 213 Gaithersburg, Md. 20877							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Painted Post, New York						
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Av., Rockville, Maryland						25. DATE REC'D. BY REGISTRAR AUG 17 1987 <u>John Darden</u>							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP _____

063054 WIG 1887

Aug 17 1987

062869 AUG 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 (removal of organs) should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 8 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY C. COLLINS			2a. DATE OF DEATH MONTH DAY YEAR August 6, 1987			2b. HOUR 7:25 AM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 30, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 98		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY LEGAL	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. COURT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA WITHROW			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 220-44-4479			17. INFORMANT ADDRESS PATRICIA C. HOGAN/DAUGHTER SAME AS 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20' 24h 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Bronchitis & organic Brain Syndrome & HTSP old									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/31/87 to 8/6/87 , that (I) (we) last saw the deceased alive on 8/4/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen N. Jones						DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN N. JONES, M.D.						22e. ADDRESS 809 VIERS MILL RD ROCKVILLE, MD 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG 8, 1987		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.		
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901						25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE Janet R. Rude	

MEDICAL CERTIFICATION

005880 and 1201

005880 and 1201

062523 AUG 13 87

FOR
STATE
REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

2 3 8 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Joseph COLLINS			2a. DATE OF DEATH MONTH DAY YEAR 08/08/87		2b. HOUR 1946M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 9, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nuclear Engineer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Damascus	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Collins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Maude Ozee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT ADDRESS Jean D. Collins, Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 3 , 19 87 , to Aug. 8 , 19 87 , that (I) (we) lost saw the deceased alive on Aug. 8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jeffrey M. Crane		DEGREE MD		22c. DATE SIGNED 8/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey M. Crane, M.D.		22e. ADDRESS 14801 Physicians La., Rockville, Md. 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Resthaven		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md. 20872			25a. DATE REC'D. BY REGISTRAR AUG 12 1987		
			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 4, and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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064691 SEP -3 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8222

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Benjamin Clifton

Conley

20. DATE KNOWN OF DEATH ☐ ESTI- ☐ MONTH DAY YEAR 8 28 1987 21. HOUR M

3 SEX

Male

4 RACE

Caucasian

5. DATE OF BIRTH

Jan. 27, 10

6. AGE (IN YEARS)

77 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

22. DATE PRONOUNCED DEAD

8 28 1987

23. HOUR M 3:15 A.M.

74. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Alabama

75. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD

10. CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

4234 Landgreen Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Highway Engineer

12b. KIND OF BUSINESS

State of Alabama

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Rockville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

4234 Landgreen Street, 20853

14. FATHER'S NAME

John

MIDDLE

C.

LAST

Conley

15. MOTHER'S MAIDEN NAME

Birtie

MIDDLE

LAST

Gordon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

W.W. II

17. INFORMANT

422-20-3322

17. INFORMANT

Mayme S. Conley Same as 13 (wife)

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

Carcinoma of Lung

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 year

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

N/A

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

Paul A. DeVore, M.D.

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE SIGNED

8-29-87

EXAMINER'S NAME

Paul A. DeVore, M.D.

ADDRESS

4206 Queensbury Road

Hyattsville, Md. 20781

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Aug. 31, 87

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Cemetery

23d. LOCATION

Rockville, Montgomery, Md.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME Francis J. Collins, Jr.

500 University Blvd. West, Silver Spring, Md.

25a. DATE REC'D BY REGISTRAR

SEP 02 1987

25b. RE

John A. ...

20901

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, AND PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP
DHMH - 17
(VR A15 ME (5))

8-20-72
8-20-72

COLORED PAPER

NOV 1972

NOV 1972



100

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063377

AUG 21 87

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 8 2 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Catherine E. Connors			2a. DATE OF DEATH MONTH 08 DAY 13 YEAR 87			2b. HOUR 1125 PM		
3. SEX Female			4. RACE C White			5. DATE OF BIRTH MONTH October DAY 21 YEAR 1901		
6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS			7. IF UNDER 1 YEAR MONTHS DAYS 			8. IF UNDER 24 HRS HOURS MIN. 		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Operator			12b. KIND OF BUSINESS OR INDUSTRY C & P					
13a. STATE Maryland			13b. COUNTY Pr. Geo.			13c. CITY OR TOWN Hyattsville		
14. FATHER'S NAME FIRST Michael MIDDLE J. LAST Connors			15. MOTHER'S MAIDEN NAME FIRST Nora MIDDLE LAST Kelly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 578-32-5120			17. INFORMANT Brother Daniel A. Connors ADDRESS 2031 Onaka Drive Orlando, Florida 32809		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) circulatory failure DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day year years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cholecystectomy Chronic obstructive lung disease pneumonia								
19a. DATE OF OPERATION 7/19/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute cholecystitis			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/8/87 to 8/12/87 , that (I) (we) last saw the deceased alive on 8/12/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.								
22b. SIGNATURE Tung PI Lee MD						DEGREE MD		22c. DATE SIGNED 8/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TUNG PI LEE MD						22e. ADDRESS 7411 Riggs Rd Hyattsville Md 20783		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 17, 1987			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd., W. Silver Spring, Md. 20901			25a. DATE REC'D. BY REGISTRAR AUG 20 1987		
25b. REGISTRAR'S SIGNATURE John Anderson-Randell								

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

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064500 SEP-28

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND-21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed while 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 2 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Christine S. Coombes			2a. DATE OF DEATH MONTH DAY YEAR August 26, 1987			2b. HOUR 10:00pm					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
12. CITY OR TOWN OF DEATH Bethesda		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7501 Democracy Blvd. #225				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY Own Home			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Montgomery		16c. CITY OR TOWN Bethesda		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 7501 Democracy Blvd. #225 / 20817		
17. FATHER'S NAME FIRST MIDDLE LAST William H. Spignul			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Meyer			19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				20. SOCIAL SECURITY NO. 123-01-0627	
21. INFORMANT Rame S. Coombes			22. ADDRESS 6700 S Redwood Court Cheyenne, WY 82009								
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Essential Hypertension										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes 10 years 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE					
34. I certify that (I) (this hospital) attended the deceased from Sept 11 19 86 to August 26 19 87, that (I) (we) last saw the deceased alive on July 6 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
35. SIGNATURE Philip R. James M.D.						36. DEGREE M.D.			37. DATE SIGNED August 27, 1987		
38. PHYSICIAN'S NAME (TYPE OR PRINT) Philip R. James M.D.						39. ADDRESS 5401 Western Avenue N.W. Washington D.C.					
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			41. DATE Aug. 29, 1987			42. NAME OF CEMETERY OR CREMATORY Montgomery Crem.			43. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland		
44. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814						45. DATE REC'D. BY REGISTRAR SEP 1 - 1987			46. REGISTRAR'S SIGNATURE Julia Anderson-Randall		

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 2 5

REG. NO.

1. DECEASED NAME (LAST OR FIRST) FR. JAMES M. COONEY			2a. DATE OF DEATH MONTH DAY YEAR 8 16 87			2b. HOUR 3:37 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Catholic Priest		12b. KIND OF BUSINESS OR INDUSTRY Religious			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 12701 Veirs Mill Rd. (20853)		14. FATHER'S NAME FIRST MIDDLE LAST Owen -- Cooney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget -- (unavailable)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No --			
16b. SOCIAL SECURITY NO.		17. INFORMANT Superior		ADDRESS Pastorial Ctr.		18. P.O. Box 29260/Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CHRONIC EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF (c) CIGARETTE SMOKING								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 15 YRS 35 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: S/P RIGHT PNEUMECTOMY (LUNG CANCER); CHRONIC C.A.D. + CHF									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from DEC 8/16 19 87 , to 8/16 19 87 , that (I) (we) last saw the deceased alive on 8/16 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R.P. Delaney MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/16/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.P. DELANEY MD		22e. ADDRESS 4323 HARVARD ST SILVER SPRG, MD 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Aug. 21, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem		23d. LOCATION CITY OR TOWN COUNTY STATE White Plains-New York			
24. FUNERAL DIRECTOR NAME DeVol Funeral Home		ADDRESS 2222 Wisc. Ave. Washington D.C.		25a. DATE REC'D. BY REGISTRAR AUG 21 1987		25b. REGISTRAR'S SIGNATURE John A. DeVol			

TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAYDE LANDSMAN COOPER		2a. DATE OF DEATH MONTH 8 - DAY 31 - YEAR 87 5:55 PM	
3. SEX Female	4. RACE caucasian	5. DATE OF BIRTH MONTH 8 - DAY 15 - YEAR 01	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor (Retired)	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring
14. FATHER'S NAME FIRST U MIDDLE n LAST k n o w n		15. MOTHER'S MAIDEN NAME FIRST U MIDDLE n LAST k n o w n	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-05-9739	
17. INFORMANT Shirley Knapp: Daughter; 915 Lamberton Drive		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Relational pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-7 days	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE D. A. ROSENBAUM	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/1/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. A. ROSENBAUM	22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20895		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/2/87	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden	23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25a. DATE RECEIVED BY REGISTRAR SEP 8 1987	25b. REGISTRAR'S SIGNATURE Julia Benson-Randall
1170 Rockville Pike; Rockville, Md. 20852			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a certain time after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be turned over to the funeral director, to be retained by him for 72 hours after death. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

JULY 1958

1

FOR Med. Ex., / Gbj.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO:

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		21. HOUR	
ANTHONY		DAVID		COSTANZA				8-5-87 19		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7. DATE PRONOUNCED DEAD		22. HOUR	
Male	White	April 10, 1960		27 YRS.				8-5-87 19		6:24P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Montgomery County				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Springs		8401 Flower Avenue Apt. 4		Asst. Manager		Auto-Sales					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		20912	
Maryland		Montgomery		Silver Springs				8401 Flower Avenue, Apt. 4			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
David Leo Costanza		Nesta Lee Richardson		no		214-80-1757		Edgewood, Md. 21040			
								David L. Costanza, 1908 Cherry Road,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Narcotic intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying cause last</u> . (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 5 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject used drugs							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) above residence		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8401 Flower Avenue, Apt. #2, Silver Spring, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED		8-6-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Margarita A. Korell, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Aug. 8, 1987		Mt. Zion Cemetery		Bel Air Harford Md.					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III, Abingdon, Md. 21009		AUG 10 1987		Julia T. Robinson-Rodwell							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE RETURN OF THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 8 2 8

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Amparo Covarrubias</i>			2a. DATE OF DEATH MONTH <i>8</i> DAY <i>26</i> YEAR <i>87</i>			2b. HOUR <i>1108 PM</i>				
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH <i>9</i> DAY <i>29</i> YEAR <i>17</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mexico</i>		7b. CITIZEN OF WHAT COUNTRY? <i>PERM. RES. U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH <i>Takoma Park, MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Maryland</i>					13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>EMILIANO</i> MIDDLE <i></i> LAST <i>PONCE</i>					15. MOTHER'S MAIDEN NAME FIRST <i>FELICITAS</i> MIDDLE <i></i> LAST <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>4164 58 2989</i>		17. INFORMANT ADDRESS <i>MELCHOR O. COVARRUBIAS - 7412 Aspen Ave T.P.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>gastrointestinal hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic colon CA with destructive panolice</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>2 years</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>										
19a. DATE OF OPERATION <i>9-23-85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Colon CA</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <i>5-1-87</i> , 19 <i>87</i> , to <i>24 July</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>25 Aug</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Verne F. Kenerer Jr</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>26 Aug 87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Verne F. Kenerer Jr</i>					22e. ADDRESS <i>Washington Adventist Hosp, 7600 Carroll Ave, Takoma Park MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug 28, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Georg Washington Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Adelphi</i> COUNTY <i>MD</i> STATE <i>MD</i>				
24. FUNERAL DIRECTOR NAME <i>Takoma Funeral Home & Crematory</i>					ADDRESS <i>257 Carroll Ave NW</i>		25a. DATE AND BY WHOM <i>AUG 31 1987</i>			
					25b. REGISTRAR'S SIGNATURE <i>John Burton</i>					

064335 269-105

1954 10 21

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

2 3 3 2 7

FOR
1 - STATE
REGISTRAR

REG. NO.

062884 AUG

1. BASED NAME (TYPE OR PRINT) Randolph		FIRST MIDDLE LAST Coyle, IV		2a. DATE OF DEATH MONTH DAY YEAR Aug. 8, 1987		2b. HOUR 11:45 am	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 17, 1920		6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 67 MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Ret. & Nursing Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Services Off.		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.	
13a. STATE DC		13b. COUNTY N/A		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Randolph Coyle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Rhett Goode		13e. STREET ADDRESS / ZIP CODE 3419 Prospect St. NW 20007			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-24-6441		17 INFORMANT ADDRESS Betty M. Tubbs Chevy Chase, MD 5509 Montgomery St. 20815			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Brain Tumor, Metastatic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 24 Hrs. 4 Months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug. 8 1987 Aug. 5 1987 to Aug. 8 1987 , that (I) (we) last saw the deceased alive on Aug. 8 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Thomas C. Havell</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 8, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas C. Havell, MD				22e. ADDRESS 4201 Cathedral Ave. NW Wash., DC 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Removal		23b. DATE 8/13/87		23c. NAME OF CEMETERY OR CREMATORY Magnolia Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Mobile, AL	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 14 1987 <i>John Davidson</i>			
5130 WI Ave. NW Wash., DC 20016							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other fact which may affect the medical examination, the medical examiner must be notified.

062884 AUG 17 87

11:47 am

Aug. 8, 1987

Coffee, IV

Washington

07

Mar. 17, 1950

White

Male

Montgomery

U.S.A.

DC

Silver Spring Chevy Chase Ref. & Nursing Ctr. Gen. Services Off. Fed. Gov't.

3419 Prospect St. NW 20007

x

Washington

WA

DC

Washington

Coffee, III

Model

Thott

Google

2509 Montgomery St. NW Chevy Chase, MD 20910

218-24-441

Hetty M. Tappa

Pulmonary disease

15 yrs.

Pneumonia

24 yrs.

Brain Tumor, Metastatic

4 months

87

Aug. 8

87

Aug. 2

87

Aug. 8

Aug. 8, 1987

x

4501 Cathedral Ave. NW Wash., DC 20016

Thomas C. Havelly, MD

Mobile, AL

Removal-Removal 8/12/87 Washington, DC

Joseph G. Galloway, Inc.

2130 W. Ave. NW Wash., DC 20016

AUG 14 1987

062179 AUG 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 8 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) A.K.A. Peggy Virginia Crosby Margarete V. Crosby				2a. DATE OF DEATH MONTH DAY YEAR 8 4 87				2b. HOUR 0858	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 20 21		6. AGE (IN YEARS LAST BIRTHDAY) 65		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bill Processing		12b. KIND OF BUSINESS OR INDUSTRY Bank	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Brentwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3601 39th Ave. 20722	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Dunn				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Lucelle Meyers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-18-0349		17. INFORMANT ADDRESS Rt. 2 Box 2365-D LaPlata, MD 20646 Peggy Keesee (daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Leukopenia DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Breast								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 hrs. 96 hrs. 1 1/2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4 Feb 1986 to 4 Aug 1987 , that (I) (we) last saw the deceased alive on 4 Aug 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or, we did not see the body after death).									
22b. SIGNATURE Thomas A. Bensinger MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger				22e. ADDRESS 7525 Greenway Ctr. Drive Greenbelt MD 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/07/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Geo. MD			
24. FUNERAL HOME NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781				25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE John Benson-Randall			

BP

085173 YAC 10 85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use on the burial-transit permit. These permits are removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 8 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERBERT Franklin DAMERON			2a. DATE OF DEATH MONTH DAY YEAR 8 5 87		2b. HOUR 940 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 06 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Bakery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN Mt. Rainier	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3205 Rhode Island Ave. #22 20712
14. FATHER'S NAME FIRST MIDDLE LAST Henry Dameron		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Crabb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II 577-05-5914		17. INFORMANT ADDRESS 7105 Bridel Path Lane Hyattsville, MD 20782	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RUPTURED AORTIC ANEURYSM DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS, Tuberculosis, Chr. subdural					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/4/87 , 19 87 , to 8/5/87 , 19 87 , that (I) (we) last saw the deceased alive on 8/5/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Tony P. Kammrath MD		DEGREE MD		22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tony P. KAMNARKAT		22e. ADDRESS 8201 16th St, SILVER SPRING, MD 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 08/10/87	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Geo. MD	
24. FUNERAL DIRECTOR'S NAME Francis Gasch's Sons Funeral Home, P.A.		24b. ADDRESS 4739 Baltimore Ave. Hyattsville, MD 20781		25a. DATE REC'D. BY REGISTRAR AUG 14 1987	25b. REGISTRAR'S SIGNATURE <i>John Swickard</i>

065828 AUG 17 81

9

063702 AUG 25 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 8 3 2	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
FIRST MIDDLE LAST Thomas Anton Daniels					August 19, 1987		p m		4:20		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		June 26, 1918		69		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Rockville, DC		USA				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital				Asst. W/Pres.		Bank			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		
Maryland			Montgomery		Silver Spring		<input type="checkbox"/> NO <input type="checkbox"/>		3642 Glen Eagles Drive 20906		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST HARRY C. DANIELS			FIRST MIDDLE LAST KATHRYN B. LYNCH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Yes		WW II		577-14-8637		MICHAEL A. DANIELS 1801 Chrystal Dr. Arl. VA 22202					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>malnutrition</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>metastatic lung cancer</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
<u>Sepsis, Perforated viscous.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
7/26/87 + 8/9/87			Perforated viscous				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			HOUR A.M. MONTH DAY YEAR P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						STREET					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/26/87</u> , 19____, to <u>8/19/87</u> , 19____, that (I) (we) last saw the deceased alive on <u>8/19/87</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Arthur F. Woodward, Jr.</u>						M.D.				8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Arthur F. Woodward, Jr., M.D.						18111 Prince Philip Drive #326 Olney, MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			8/24/87		Parklawn Cem.			Rockville, MD COUNTY STATE			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016						AUG 24 1987			<u>Julia Davidson-Parker</u>		

BP

083105 105281

stop

RECEIVED

10/11/50

10/11/50

10/11/50

10/11/50

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062334 AUG 11 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Donald Dale Davis			2a. DATE OF DEATH MONTH 8 DAY 4 YEAR 87			2b. HOUR 2020 P.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Aug DAY 23 YEAR 1937		6. AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Shady Grove		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SAFeway Stores Inc. (Stock)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12901 Atlantic ST. (20851)	
14. FATHER'S NAME FIRST Nelson MIDDLE - LAST DAVIS			15. MOTHER'S MAIDEN NAME FIRST Esther MIDDLE - LAST Hendra							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1959		17. INFORMANT Kevin Davis ADDRESS 12901 Atlantic Street, Rockville, Md. 20851					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC NON OAT CELL CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from NOVEMBER 12 19 86 to AUGUST 4 19 87 , that (I) (we) last saw the deceased alive on JULY 23 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
23a. SIGNATURE James A. Brown, MD				DEGREE				23b. DATE SIGNED 8/5/87		
24. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD				25a. ADDRESS 14801 PHYSICIANS LANE #27 Rockville Md. 20850						
23a. BURIAL, CREMATION, REMOVAL (CITY) Burial		23b. DATE 8-8-87		23c. NAME OF CEMETERY OR CREMATORY MT. View Cemetery		23d. LOCATION CITY OR TOWN Moscow Mills, Allegany COUNTY MD				
24. FUNERAL DIRECTOR NAME James E. McKee ADDRESS Louisa, MD				25b. DATE REC'D BY REGISTRAR AUG 20 1987		25c. REGISTRAR'S SIGNATURE James Davidson-Randall				
FURNISHED BY: Eichhorn-McKenzie Funeral Home, 21537										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

069003 AUG 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA MAY DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 08/03/87		2b. HOUR 608am	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 04/16/30		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Indies		7b. CITIZEN OF WHAT COUNTRY? Jamaica		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 74 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5524 Besley Cr. 20851		12b. KIND OF BUSINESS OR INDUSTRY Private		
4. FATHER'S NAME FIRST MIDDLE LAST Wilfred Holness		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Ford		17. INFORMANT ADDRESS Masie Marsh 6106 63rd Ave. Riverdale		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 263-64-9189		17. INFORMANT ADDRESS Masie Marsh 6106 63rd Ave. Riverdale		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Not Known</u> <u>Not Known</u> <u>Not Known</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Asthma</u>						
19a. DATE OF OPERATION <u> </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>mid</u> , 19 <u>70's</u> , to <u>June/July</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>June/July</u> , 19 <u>87</u> , and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Ronald Shore</u>				22c. DATE SIGNED 8/3/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ronald Shore</u>				22e. ADDRESS <u>9900 Georgia Ave., Silver Spring Md 20902</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/87		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Cemetery Suitland, MD		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <u>R.N. Norton Co. Inc.</u>				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		
24. FUNERAL DIRECTOR ADDRESS <u>600 Kennedy St. N.W. DC</u>				25b. REGISTRAR'S SIGNATURE <u> </u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

062150 AUG 16 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
James B. Davis			August 2, 1987			6:40 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))			7. IF UNDER 1 YEAR		
Male	Caucasian	10 25 16	70 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, DC	USA		Montgomery County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital		Dir Admin Services N.I.H.					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
Maryland	Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	10712 Lorain Avenue 20901				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
James B. Davis, Sr.		Violet Paul						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
yes		1944-1945		Irene T. Davis/wife same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET OF ILLNESS AND DEATH
IMMEDIATE CAUSE (a) Cancer								2 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary arteriosclerosis								yes
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes Mellitus								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/2 May 73 to 8/2 87, and that (I) (we) last saw the deceased alive on 8/2 May 73, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (did) not have the body after death.								
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN		22e. MEDICAL STAFF PHYSICIAN		22f. DATE SIGNED
Alan T. Kermaier, MD		MD		8/2/87				8/2/87
22g. PHYSICIAN'S NAME (TYPE OR PRINT)		22h. ADDRESS						
ALAN T. KERMAIER		10313 Georgia Ave. S.E. MD 20032						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Aug 6, 1987		Gate of Heaven		Silver Spring Montgomery MD		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis J. Collins, Jr.				AUG 7 1987		Julia Davidson-Randall		
500 University Blvd., W Silver Spring, MD 20901								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

065120 APR 10 81

Handwritten notes on lined paper, including the phrase "Silver Spring High School Hospital" and other illegible text.



062727 AUG 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Faustina Graciela C. De Baigorria			2a. DATE OF DEATH MONTH DAY YEAR August 12, 1987		2b. HOUR 3:50p M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR November 11, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lima, Peru	7b. CITIZEN OF WHAT COUNTRY? Peru	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Potomac	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8308 Post oak Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	
14. FATHER'S NAME FIRST MIDDLE LAST Alejandro Carbajal			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Faustina Ferreir		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-98-4513		17. INFORMANT Jose Baigorria 8308 Post oak Road Rockville, Maryland 20854 (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Terminal Colon Carcinoma - Metastatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 19 87, to August 11, 19 87, that (I) (we) lost saw the deceased alive on August 11, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 				22c. DATE SIGNED August 12, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose A. Quiros M.D.				22e. ADDRESS 4343 Montgomery Avenue #101 Bethesda, Maryland 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE August 12, 1987		23c. NAME OF CEMETERY OR CREMATORY British Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Lima, Peru		24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Cherry Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814			
25a. DATE RECEIVED BY CLERK AUG 13 1987				25b. DATE RECEIVED BY CLERK AUG 13 1987	

BP

085353 AUG 14 83

COLLECTOR FIELD

AUG 13 1981

064046 AUG 28 87

FOR STATE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 37

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER'S OFFICE, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI. DEATH MATED			MONTH DAY YEAR			7b HOUR			
James Henry Deel						8-20-87						M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		7d HOUR	
Male		Caucas.		Jan. 10, 1937		50 YRS.		MONTHS DAYS		HOURS MIN		8-20 1987		8:04 P M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
S. Carolina				United States								Montgomery County MD			
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Gaithersburg				18610 Nut Hatcher Lane				Service Tech.				Manufactur-			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS		20879 ing					
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18610 Nut Hatcher Lane							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME									
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST					
Henry		Edison		Deel		Esther		Hiers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS			
Yes				Korea				577 50 2560				Wife Evelyn T. Deel Same as item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
Diabetes Mellitus															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								70 AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
TITLE (SPECIFY) Assistant MEDICAL EXAMINER															
DATE 8-21-87 SIGNED															
EXAMINER'S NAME Charles P. Kokes, M.D. ADDRESS 111 Penn Street, Baltimore, MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Aug. 25, 1987 23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland															
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOME ROCKVILLE, INC. 300 West Montg. Avenue Rockville, Maryland 25a. DATE REC'D BY REGISTRAR AUG 26 1987 25b. REGISTRAR'S SIGNATURE															

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

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APR 26 1983

062459 AUG 2 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 3 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Pearson De Luca			2a. DATE OF DEATH MONTH DAY YEAR August 10, 1987		2b. HOUR 7:55A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 1, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8605 Howell Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Insurance
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8605 Howell Road / 20817	
14. FATHER'S NAME FIRST MIDDLE LAST William M. Howdershell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte E. Owens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT ADDRESS Mr. Alfred De Luca, Husband, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 19 87</u> to <u>AUG 10 87</u> , that (I) (we) last saw the deceased alive on <u>AUG 7 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Bruce A. Silver</u> MD				22c. DATE SIGNED August 10, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) for Dr. Frederick Barr		22e. ADDRESS 5454 Wisconsin Avenue, #835 Chevy Chase, Maryland 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE August 13, 1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland	25a. DATE REC'D. BY REGISTRAR AUG 11 1987	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814			25b. REGISTRAR'S SIGNATURE <u>Caroline [Signature]</u>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

1954 28 JUNE 15 81

061804

AUG 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amelia DeSimone			2a. DATE OF DEATH MONTH DAY YEAR Aug. 1, 1987		2b. HOUR 10:45 ^A M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 6 1892		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Ciociola					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angelina Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 44 7610J		17. INFORMANT ADDRESS Salvatore DeSimone (Son) Same as 13E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE WEEK		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CHRONIC ORGANIC BRAIN SYNDROME; SENSORY DEPRIVATION AND CACHEXIA										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from June 11, 1987, to Aug 1, 1987, that I (we) last saw the deceased alive on 7/29/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b. SIGNATURE MARTIN C. SHANGEL				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/1/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHANGEL				22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON MD - 20895						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-4-1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION Suftland Pr. Georges Md.				
24. FUNERAL DIRECTOR Name Rinaldi Funeral Home				11800 N. H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR AUG 04 1987		25b. REGISTRAR'S SIGNATURE Julia Benson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

065187 SEP 10 87

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Spiro Diamond			2a. DATE OF DEATH MONTH DAY YEAR 8-31-87		2b. HOUR 10 ¹⁰ PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 14 03	6. AGE (IN YEARS LAST BIRTHDAY) 84		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Albania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NSG Home		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Food Services		12b. KIND OF BUSINESS OR INDUSTRY Spartan Springs C.C.
13a. STATE Md.		13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 13701 Alderton Road 20906
14. FATHER'S NAME FIRST MIDDLE LAST Spiro Diamond		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alexandria Bacos			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO 110 12 6910		17. INFORMANT ADDRESS Matai Diamond (Wife) Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 887 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Stroke multiple type 2 DUE TO, OR AS A CONSEQUENCE OF (c) Fracture of hip, falls from stairs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Fracture of hip, falls from stairs					
19a. DATE OF OPERATION 8/17/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED fracture hip		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/31/87	
22a. I certify that (i) (this hospital) attended the deceased from 8/31/87 to 8/31/87 that (i) (we) last saw the deceased alive on 8/31/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death.					
22b. SIGNATURE C. H. Ligon MD		DEGREE MD		22c. DATE SIGNED 8/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1814 P. Phillips Dr, Olney MD 20832			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE 9/3/87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alex. Va.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md		25a. DATE REC'D. BY REGISTRAR SEP 09 1987		25b. REGISTRAR'S SIGNATURE Julia Swenson-Rodriguez	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If page 3 is marked or initialed, it is not valid for use.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23841
REG NO.

1. DECEASED NAME (TYPE OR PRINT) Jane H. Dickey		2a. DATE OF DEATH MONTH DAY YEAR August 21, 1987		2b. HOUR 11:00a	
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MC AR October 23, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Garrett Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10715 Weymouth Street		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b KIND OF BUSINESS OR INDUSTRY Own Home
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Garrett Park	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William Blake Hindman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margret Ballard			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 200-07-7883		17. INFORMANT ADDRESS Robert A. Dickey Same as # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE CARDIO-RESPIRATORY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION					1 DAY
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE					20 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 EMPHYSEMA					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from about 1964 to AUG. 21, 1987 , that (I) was did not view the deceased alive on AUG. 7, 1987 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above. (I) did not did view the body after death.					
22b SIGNATURE Joseph D. Connor, MD		DEGREE MD		22c DATE SIGNED 8/21/87	
22b PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH D. CONNOR, MD		22c ADDRESS 9420 OLD GEORGETOWN RD, Bethesda, MD 20814			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE August 26, 1987		23c NAME OF CEMETERY OR CREMATORY Grandview Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Chillicothe Ross Ohio		23e DATE REC'D. BY REGISTRAR AUG 26 1987			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey		24b FUNERAL HOME/ ADDRESS Bethesda-Chevy Chase Inc. Bethesda, Md. 20814		25b REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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CHINESE-AMERICAN
ACUTE MYOCARDIAL INFARCTION 1 DAY
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AMERICAN

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Joseph H. Connor
2020 H. D. Connor, Jr. 1110 Old Government Bldg
Wash DC 20540
4/11/81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23842

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME FIRST MIDDLE LAST MILDRED DIFATE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 28, 1987		2b. HOUR A 2:00 M
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 28, 1897		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH GERMANTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13118 Shadyside Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.		13b. COUNTY MONT.	13c. CITY OR TOWN GERMANTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST DOMINIC - GARAGUSO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GAETANA - PELETIERI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 127-20-3456A		17. INFORMANT ADDRESS ANTHONY DIFATE SAME AS # 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Pulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) possible Acute CVA. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/28/87 19 86 to 8/28/87 19 87 that (I) (we) last saw the deceased alive on 8/28/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE John D. Khianey		DEGREE		22c. DATE SIGNED 8/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HIRU D. KHIANEY		22e. ADDRESS 20428 Germantown Rd.			
23a. BURIAL, CREMATION, REMOVAL (15) BURIAL		23b. DATE SEPT. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM VET. CEM.	
23d. LOCATION (15) CHELTENHAM P. GEORGE MD.		23e. DATE REC'D BY REGISTRAR (15) SEP 02 1987			
24. FUNERAL DIRECTOR MURIEL H. BARBER LAYTONSVILLE, MD. 20879					

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 4 5
REG. NO.

1 DECEASED NAME (PRINT) FIRST MIDDLE LAST Petrina S DiLosa		2a DATE OF DEATH MONTH DAY YEAR 8/13/87		2b HOUR 12:20 M	
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR 7/9/01		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Orleans	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp, 1500 Forest glen Rd.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS / ZIP CODE 903 Kersey Road 20902					
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Scaglione		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Scaglione			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 439-50-1839		17 INFORMANT ADDRESS Vincent J. DiLosa/son same as 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 weeks</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (the hospital) attended the deceased from <u>18 AUG 1982</u> to <u>13 AUG 1987</u> that (we) last saw the deceased alive on <u>12 aug 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Walter E. Goode</u> DEGREE <u>MD</u>				22c DATE SIGNED <u>13 aug 87</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER E. GOODE MD</u>				22e ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Aug 13, 1987		23c NAME OF CEMETERY OR CREMATORY Metropolitan	
23d LOCATION CITY OR TOWN Alexandria		23e COUNTY Virginia		23f STATE	
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. W Silver Spring, MD 20901				25a DATE REC'D. BY REGISTRAR AUG 20 1987	
25b REGISTRAR'S SIGNATURE <u>L. J. Davidson-Randall</u>					

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FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 4 4

REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Thomas Aloysius Doherty					August 31, 1987				10:00am
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	Caucasian	November 8, 1936			50 YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Ohio	United States				Montgomery County, MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	1215 Broadwood Drive				Owner		Restaurant		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE					13c. STREET ADDRESS / ZIP CODE				
Maryland					1215 Broadwood Drive / 20851				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
William C. Doherty					Gertrude Helen Dacey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
Yes					Korea 577 46 4900				
17. INFORMANT (Wife)					Kathleen Denise Doherty Same as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Cardiac Arrest					3 years				
Dilated Cardiomyopathy									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 7/11/85 to 8/31/87, that (I) last saw the deceased alive on June 11, 1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
Herman C. Maganzini, M.D.									
22e. ADDRESS									
9711 Medical Center Dr. Rockville, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Sept. 4, 1987		Gate of Heaven Cem.		Silver Spring Maryland			
24. FUNERAL DIRECTOR					25a. DATE REC'D BY REGISTRAR				
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland					SEP 8 - 1987				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18, it has an injury, or other traumatic event, the medical examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

002050 209-001

James Earl Ray
The Criminal

James Earl Ray
The Criminal
8/11/84

SEP 8 - 1984

062458 AUG 12 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 8 4 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Charles Doherty			2a. DATE OF DEATH MONTH DAY YEAR August 09, 1987		2b. HOUR 6:15p M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 23, 1902		6. AGE [IN YEARS LAST BIRTHDAY] 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ambassador		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government
13a. STATE Florida		13b. COUNTY Polk	13c. CITY OR TOWN Nalcrest	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 5977 33856 99999
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Michael Doherty			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Ryan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1919-1922 579 22 4780		17. INFORMANT (Son) ADDRESS James F. Doherty 8607 Springvale Rd Silver Spring, Md. 20910	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Weeks 10 Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) XXXXXX attended the deceased from July 27, 1987 to August 9, 1987 that (I) (X) lost saw the deceased alive on August 8, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Christopher C. Dunford</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED August 10, 1987					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher C. Dunford, M.D.				22e. ADDRESS 615 West Montgomery Ave. Rockville, Md. 20850	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland					
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. ADDRESS 7557 Wisconsin Avenue, Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR AUG 11 1987	
				25b. REGISTRAR'S SIGNATURE <i>Sandra Arnold</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ethel A. Donovan			2a. DATE OF DEATH MONTH DAY YEAR 08-01-87		2b. HOUR 8:45 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09-23-98		6. AGE (IN YEARS LAST BIRTHDAY) 91	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE --			13b. COUNTY --	13c. CITY OR TOWN Washington, DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry Bertram			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Thomas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (daughter) ADDRESS Carolyn D. Spain 15002 Lear Lane Silver Spring, Md. 20904	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 9289 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Divericulitis with (c) Perforation of bladder					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Aug. 1, 1987		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 19 85 to present, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) sign the above after death.					
22a. SIGNATURE John J. Merendino, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 1, 1987	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-5-1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR AUG 04 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VIA 15, 4)

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062715 AUG

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 1527 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL
Cremation23b. DATE
8-11-198723c. NAME OF CEMETERY OR CREMATORY
Balt. Wash. Crematory23d. LOCATION
Laurel, Pr. Geo., Md

24. FUNERAL DIRECTOR

NAME
Takoma Fun'L Home. N.W., Wash.D.C. 20012

ADDRESS

DATE REC'D BY REG. CLERK
AUG 13 198725b. REGISTRY SIGNATURE
[Signature]STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23841

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES VANICE DOTY			2a. DATE OF DEATH MONTH DAY YEAR 8 9 87			2b. HOUR 1500 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 10. 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY PR GEO		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DON F VANICE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNICE BUSEY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 213-46-7136		17. INFORMANT KEITH T. DOTY 12517 SWIRL LANE BOWIE MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Parkinson disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>SEIZURE DISORDER, Renal insufficiency</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22a. certify that (I) (this hospital) attended the deceased from 8/9 1987, to 8/9 1987, that (I) (we) last saw the deceased alive on 8/9 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE [Signature]		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIPAPORN WOODWARD		22e. ADDRESS 5530 WISCONSIN AVE, CHEV CHASE, MD					
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 8-11-1987		23c. NAME OF CEMETERY OR CREMATORY Balt. Wash. Crematory		23d. LOCATION Laurel, Pr. Geo., Md	
24. FUNERAL DIRECTOR NAME Takoma Fun'L Home. N.W., Wash.D.C. 20012		ADDRESS		DATE REC'D BY REG. CLERK AUG 13 1987		25b. REGISTRY SIGNATURE [Signature]	

BP

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STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) First: <u>Theodore</u> Middle: <u>Dreskin</u> Last: <u>Dreskin</u>			2a. DATE OF DEATH MONTH: <u>8</u> DAY: <u>14</u> YEAR: <u>1987</u>		2b. HOUR <u>2:00 AM</u>										
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH: <u>5</u> DAY: <u>22</u> YEAR: <u>24</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>63</u> YRS.		7. UNDER 1 YEAR MONTHS: <u>0</u> DAYS: <u>0</u> HOURS: <u>0</u> MIN: <u>0</u>		8. UNDER 24 HRS. HOURS: <u>0</u> MIN: <u>0</u>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.									
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Salesman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Men's clothing</u>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: <u>MD</u> 13b. COUNTY: <u>Montgomery</u> 13c. CITY OR TOWN: <u>Silver Spring</u>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>1014 Osage St.</u> <u>20903</u>							
14. FATHER'S NAME First: <u>Hyman</u> Middle: <u>Dreskin</u> Last: <u>Dreskin</u>			15. MOTHER'S MAIDEN NAME First: <u>Ida</u> Middle: <u>Braunman</u> Last: <u>Braunman</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> UNKNOWN <input type="checkbox"/> IF YES, (GIVE BRANCH AND DATES) <u>WW 2</u>						16b. SOCIAL SECURITY NO. <u>100-14-7270</u>		17. INFORMANT <u>14563 Transhire Road, Irwin Neal Dreskin Gaithersburg, Md. 20879</u>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b): <u>Myeloma</u> DUE TO, OR AS A CONSEQUENCE OF (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 d</u> <u>3 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypocalcemia; Renal insufficiency</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (a) (this hospital) attended the deceased from <u>6/13</u> 19 <u>87</u> , to <u>8/14</u> 19 <u>87</u> , that (a) (we) last saw the deceased (b) (we) (did not) view the body after death.															
22b. SIGNATURE <u>Peter B. Sherer MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/14/87</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Peter B. Sherer MD</u>						22e. ADDRESS <u>3947 Ferrara Dr. Wheaton MD</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>8/16/1987</u>			23c. NAME OF CEMETERY OR CREMATORY <u>District of Columbia</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D. C.</u>						
24. DONOR AND DIRECTOR <u>STEIN HEBREW MEMORIAL FUNERAL HOME</u> <u>232 CARROLL STREET, N. W., WASHINGTON, D. C.</u>						25a. DATE REC'D. BY REGISTRAR <u>AUG 18 1987</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 4 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Fernie O. Dronenburg			2a. DATE OF DEATH MONTH DAY YEAR 8-19-87		2b. HOUR 3:44 M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 11, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Burtonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alburn H. Watkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Janette Broadhurst		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-48-4329	
17. INFORMANT ADDRESS James G. Dodson, Sr. Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION. DUE TO, OR AS A CONSEQUENCE OF AORTIC STENOSIS, CORONARY (b) ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF ATHEROSCLEROSIS (c) ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PERIPHERAL VASCULAR OCCLUSIVE DISEASE.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 m' 10 YEARS. 50 YEARS.			
19a. DATE OF OPERATION 8/19/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PERIPHERAL VASCULAR INSUF.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART I OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE 18111 PRINCE PHILIP DR. OLNEY MD.	
22a. I certify that (I) (this hospital) attended the deceased from 8/10/87 19____, to 8/19/87 19____, that (I) (we) last saw the deceased alive on 8/19/87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE M.D.		22c. DATE SIGNED 8/19/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIO H. DIAZ M.D.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Bethesda United Methodist Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Browningsville Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		24b. ADDRESS Bethesda-Chevy Chase, Inc. 7537 Wisconsin Ave. Bethesda, Maryland 20814		24c. DATE OF BURIAL AUG 26 1987		24d. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

BP

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23850

1. DECEASED NAME (TYPE OR PRINT) ANNETTE BROWN DUNN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30 1987			2b. HOUR P M 9:40			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 19 1929		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE DISTRICT OF COLUMBIA					13b. CITY OR TOWN COLUMBIA		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES MACON BROWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE HOLT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS ROBERT F. DUNN, QUARTERS D, NAVAL OBSERVATORY, WASHINGTON, DC 20392				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC BREAST CARCINOMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 27 , 19 87 , to AUGUST 30 , 19 87 , that (I) (we) last saw the deceased alive on AUGUST 30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R.M. Keating</i> MD						DEGREE MD		22c. DATE SIGNED 31 Aug 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. KEATING, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE Sep. 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Bay View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pensacola, Florida		
24. FUNERAL DIRECTOR NAME ADDRESS MONEY & KING VIENNA FUNERAL HOME, 171 W. Maple Ave., Vienna, Va. 22180						25a. DATE REC'D. BY REGISTRAR SEP 3 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANGEL MARIE DUTY						2a. DATE OF DEATH MONTH DAY YEAR AUGUST 24 1987		2b. HOUR 3:04 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 6, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MED RECORDS TECH		12b. KIND OF BUSINESS OR INDUSTRY ARMED FORCES	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5315 RANDOLPH ROAD 20852	
14. FATHER'S NAME FIRST MIDDLE LAST GILBERT J. DUTY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE SABO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1964-1977		17. INFORMANT SISTER CHRISTYNE NASBE		ADDRESS 5800 VALERIAN LANE ROCKVILLE, MD. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL BLEEDING</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>THROMBOCYTOPENIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHEMOTHERAPY FOR ACUTE LEUKEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 days 7 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NEUTROPENIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 3rd</u> , 19 <u>87</u> , to <u>AUGUST 23</u> , 19 <u>87</u> , that (I) (we) lost <u>the deceased</u> on <u>AUGUST 18th</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) certify the body after death.)									
22b. SIGNATURE 				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVERARD H. HUGHES, M.D.				22e. ADDRESS 8300 CORPORATE DRIVE LANDOVER, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 28, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901				25. DATE REC'D. BY REGISTRAR AUG 31 1987		26. REGISTRAR'S SIGNATURE 			

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AUG 31 1961

063971 AUG 29 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 3 5 2
REG. NO

1. DECEASED NAME (TYPE OR PRINT) Francis X. Dwyer			2a. DATE OF DEATH MONTH DAY YEAR Aug. 21, 1987		2b. HOUR 10 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1902		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4217 Oak Ridge Lane		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		
14. FATHER'S NAME FIRST MIDDLE LAST Frank O. Dwyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridgett -- McNamara		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-3369		17. INFORMANT 10901 Adams Way Walter Dwyer, Kensington, MD 20895		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PAROXYSMAL TACHYCARDIA						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 8/12 , 19 87 , to 8/21 , 19 87 , that (we) lost saw the deceased above (we) did not see the body after death.						
22b. SIGNATURE Ralph M. Coan				22c. DATE SIGNED 8/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph M. Coan				22e. ADDRESS 4400 East-West Hwy., Bethesda, MD 20814		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Wash., DC		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				
25a. DATE REC'D. BY REGISTRAR AUG 26 1987				25b. REGISTRAR'S SIGNATURE Richard Rudek		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked "b", item 18 shows any injury, or other traumatic cause of death, the cause of death must be certified at once.

BP

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NO	NAME	ADDRESS	CITY	STATE	ZIP	DATE	TIME	REMARKS
1	Mr. J. H. Smith	1001 Elm St.	Springfield	Ill.	62761	10/15/68	10:30	Initial contact
2	Mr. J. H. Smith	1001 Elm St.	Springfield	Ill.	62761	10/15/68	11:00	Follow up call
3	Mr. J. H. Smith	1001 Elm St.	Springfield	Ill.	62761	10/15/68	11:30	Final call
4	Mr. J. H. Smith	1001 Elm St.	Springfield	Ill.	62761	10/15/68	12:00	End of call

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23853				
1. FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
FIRST MIDDLE LAST					MONTH DAY YEAR					MONTHS DAYS HOURS MIN.				
John G Early					August 13, 1987					2:20am				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		8. UNDER 24 HRS.				
male		caucasian		MONTH DAY YEAR		65 YRS		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Illinois		United States				Montgomery County MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Derwood		17512 Beauvoir Blvd				Printing Officer		U.S. Gov't						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS / ZIP CODE				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					17512 Beauvoir Blvd. / 20855				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Eugene Early, Sr.					Irene Downing									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
yes					WWII		333 14 4143 Marie D. Early wife, see #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Lung										4 months				
DUE TO, OR AS A CONSEQUENCE OF (b)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (the hospital) attended the deceased from April 30, 1987, to Aug 11, 1987, that (I) (we) lost saw the deceased alive on Aug 11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Jeffrey M. Crane									8-13-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
JEFFREY M. CRANE					14801 Physician's Lane Suite 271 Rockville, MD 20850									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial		Aug 17, 1987		St. Augustines Cemetery		Valley Forge, Penna.								
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Av., Rockville, Maryland 20850					AUG 17 1987		John Davidson							

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REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Lowell MIDDLE Laszlo LAST Ecker-Racz			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH Aug DAY 5 YEAR 1987			2b. HOUR 8:15 AM											
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH Nov DAY 25 YEAR 1906		6. AGE (IN YEARS) BIRTHDAY 8 YEARS		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN.		IF UNDER 24 HRS. HOURS 0 MIN.		2c. DATE PRONOUNCED DEAD MONTH Aug DAY 5 YEAR 1987			2d. HOUR 8:15 AM								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH St. Spg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist				12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY Mont CITY OR TOWN St. Spg								13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 14708 Pebblestone Dr.													
14. FATHER'S NAME FIRST Ignatz MIDDLE I. LAST Ecker				15. MOTHER'S MAIDEN NAME FIRST Teresz MIDDLE Racz				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII								16b. SOCIAL SECURITY NO. 226-46-9545				17. INFORMANT ADDRESS Maria T. Sheetz 14708 Pebblestone Dr. Silver Spring Md. 20904			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888 IMMEDIATE CAUSE (a) Brain Damage Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause lost. (b) Subdural Hematoma (c) Fall APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days 6 days																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None																							
19a. DATE OF OPERATION 2-31-87				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Rt. Subdural Hematoma								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 9 MIN 3 MONTH 7 DAY 3 YEAR 1987 P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall on drive way															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET Pebblestone Dr. CITY OR TOWN St. Spg COUNTY Mont STATE MD															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																							
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER Page				DATE SIGNED Aug 5 1987											
EXAMINER'S NAME (TYPE OR PRINT) Dr. John S. Rogers				ADDRESS 1919 Seminary Rd. S.S. Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 8-6-87				23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN Alexandria COUNTY Virginia STATE											
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. Silver Spring Md. 20904				25a. DATE REC'D. BY REGISTRAR AUG 12 1987				25b. REGISTRAR'S SIGNATURE Julia Dindon-Ruback															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WHEN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<div>FOR</div> <div>1- STATE REGISTRAR</div> <div>REG. NO. 87 23855</div>											
1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE C.			LAST EONTA		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 12 29		6. AGE (IN YEARS) (LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD	
10. CITY OR TOWN OF DEATH Bethesda,				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Waste Control	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Pennsylvania		13b. COUNTY Allegheny		13c. CITY OR TOWN McKees Rocks		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1200 Holmes		15436 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Dominic Enota						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Papogallo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 210-20-7642		17. INFORMANT ADDRESS Lucille Eonta same address as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 7-11-87			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 WISCONSIN AVE							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE July 15, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE McKees Rocks, Pa.	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Arlington, Va 22201						25a. DATE REC'D BY REGISTRAR JUL 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

07/84
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AUG 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23850

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hattie Eppsteiner			2a. DATE OF DEATH MONTH DAY YEAR 8/18/87		2b. HOUR 8¹⁰ P M		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 10 25 94		6. AGE (IN YEARS LAST BIRTHDAY) 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Kahn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie (Unknown)		13e. STREET ADDRESS / ZIP CODE 8600 Jones Mill Road (20815)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 063-52-1168		17. INFORMANT Richard G. Eppsteiner; Son; 9512 Barroll Lane;		ADDRESS Kensington, Md. 20895	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/18 19 87 to 8/18 19 87 , that (I) (we) last saw the deceased alive on 8/18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23a. SIGNATURE Louis Kozloff				DEGREE MD		23b. DATE SIGNED 8/19/87	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS KOZLOFF, MD				23d. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD. 20814			
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23f. DATE 8/20/87		23g. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23h. LOCATION CITY OR TOWN COUNTY STATE Greenburgh; Westchester; N.Y.	
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR AUG 21 1987		25b. REGISTRAR'S SIGNATURE J. H. Davidson	

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or air removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 5 7
REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ryan J. Esposito		2a. DATE OF DEATH MONTH DAY YEAR August 8, 1987		2b. HOUR 7:00a M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 26, 1986		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. YRS. 10 12	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 Lynch Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Worked		12b. KIND OF BUSINESS OR INDUSTRY Never Worked	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James W. Esposito		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen Allgaier		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 213-13-3385		17. INFORMANT James W. Esposito (Father) 6 Lynch Court Rockville, Maryland 20850					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERCALCEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SARCOMA OF PELVIS WITH BRAIN + SPINAL METASTASES</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 minutes</u> <u>24 hours</u> <u>6 1/2 months</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>9/26/86</u> 19 <u>86</u> to <u>8/8</u> 19 <u>87</u> that (we) lost <u>2/27</u> 19 <u>87</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Karen H. Yoker, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED August 8, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karen Tokor M.D.				22e. ADDRESS 14804 Physicans Lane Rockville, Maryland 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Assumption Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Syracuse, New York	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR AUG 11 1987			

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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 3 5 8

REG. NO.

065027 SEP - 9 87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie D. Faatz			2a. DATE OF DEATH MONTH DAY YEAR August 31, 1987		2b. HOUR 6:10PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 24, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland				13b. COUNTY Prince George's		13c. CITY OR TOWN Capitol Heights	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 9402 Dogwood Park Street 20743			
14. FATHER'S NAME FIRST MIDDLE LAST Not Available				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-07-5274		17. INFORMANT ADDRESS Robert D. Faatz same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of lung DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from August 10, 1982, to August 31, 1987, that (I) (we) last saw the deceased alive on August 31, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] 22c. DEGREE 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan R. Weinstock, M.D.				22e. ADDRESS 10313 Georgia Avenue Silver Spring, MD 20902 22f. DATE SIGNED September 1, 1987			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE Sept. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY Montgomery Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland	
24. FUNERAL DIRECTOR Rockville, Inc. 300 West Montgomery Ave. Rockville, MD				25. DATE REC'D. BY REGISTRAR SEP 8 - 1987 26. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

19

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove coffin labels. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

082057 SEP-88

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SEP 8 1988

063345 AUG 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23857
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LADYS M. FAGAN			2a. DATE OF DEATH MONTH DAY YEAR Aug 17, '87		2b. HOUR MIN. 1:45 A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 2 22 08		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING SYLVAN MANOR		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PLANT WORKER	12b. KIND OF BUSINESS OR INDUSTRY PHARMACEUTICAL
13a. STATE MARYLAND		13b. COUNTY PR GEORGES	13c. CITY OR TOWN BLADENSBURG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM W. GAWEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA E. REAMY		16. STREET ADDRESS / ZIP CODE 4111 54TH STREET 20710	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-12-4767		17. INFORMANT DAUGHTER ADDRESS 8615 MAYFAIR PLACE SILVER SPRING, MD 20910	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiorespiratory DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/17/87 to 8/17/87 , that (I) (we) last saw the deceased alive on 8/17/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Myron L. Lenkin		DEGREE MD		22c. DATE SIGNED 8/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e. ADDRESS 2309 SHOREFIELD RD WHITEHAWK, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG20,1987	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PR GEORGES, MARYLAND
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		ADDRESS 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901		25. DATE REC'D. BY REGISTRAR AUG 20 1987	

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064097 AUG 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23860

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVELYN P. FALES			2a. DATE OF DEATH MONTH DAY YEAR 8-16-87			2b. HOUR 3:15 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-3-1912		6. AGE (IN YEARS, LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A., New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grovsnor Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY US Gov., t.	
13a. STATE D.C.		13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2500 Wisconsin Ave. 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Herschel Clifford Parker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Naesele			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. unavailable			17. INFORMANT Cynthia p. Hewitt			ADDRESS 1201 Walsh La. Roundrock, Texas 78681			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CardioRespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 8-4-87 to 8-16-87 that (I) (last) saw the deceased alive on 8-14-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Tauber				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber				22e. ADDRESS 8218 WISCONSIN AVE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/17/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.			
24. FUNERAL DIRECTOR NAME DeVol Funeral Home, Inc. 2222 Wisc. Ave., NW., Wash., DC 20007									
DATE REC'D. BY REGISTRAR AUG 27 1987 REGISTRAR'S SIGNATURE Julian Davidson-Randall									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Female	White	U.S.A., New York	Montgomery
Barbara	Granger Medical Center	Secretary	US G. I.
M. D.C.	Washington	3500 Wisconsin Ave.	
Michael	Clifford Barker	Swain	Female
No	unavailable	Cynthia P. Hewitt	1901 Walnut St., Houston, Texas 77001

Washington
Level 1, Federal House, Inc.
2000 West Ave., Wash. DC 20007

062905 AUG 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23861

1. DECEASED NAME (TYPE OR PRINT) JOHN E Fanning			2a. DATE OF DEATH MONTH DAY YEAR Aug. 10 87		2b. HOUR 2:10 PM
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 08 17 15		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Watch Maker		12b. KIND OF BUSINESS OR INDUSTRY Jeweler
13a. STATE Maryland			13b. COUNTY Prince Geo.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank M. Fanning			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes M. Suit		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Della Fanning (wife) Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sepsis, pneumonia, renal failure DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/10 , 19 87 , to 8/10 , 19 87 , that (I) (we) last saw the deceased alive on 8/10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael S. Lippe M.D.				22c. DATE SIGNED 8/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael S. Lippe M.D.				22e. ADDRESS HOLY CROSS HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/13/87		23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. Cheltenham Prince Geo. MD	
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A.		24b. ADDRESS 4739 Baltimore Ave. Hyattsville, MD 20781		25a. DATE REC'D. BY REGISTRAR AUG 14 1987	
				25b. REGISTRAR'S SIGNATURE Julia Tridinger-Rendall	

MEDICAL CERTIFICATION

F

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

(1)

10/12/83

062871 AUG 17 87

FOR
TE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 3 6 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William H. Faux			2a. DATE OF DEATH MONTH DAY YEAR 8-6-87			2b. HOUR 5:00 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12-06-31		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Physicist		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8009 Riggs Road 20783	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick W. Faux				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odessa Kessler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954-56		17. INFORMANT Mark Faux Son		ADDRESS Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatorenal Syndrome DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis with decompensated liver disease DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 6 wks 2 wks.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/3 1987 to 8/6 1987, that (I) (we) lost saw the deceased alive on 8/6 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marvin Schneider, M.D.				DEGREE M.D.				22c. DATE SIGNED 8/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN SCHNEIDER, M.D.				22e. ADDRESS 12001 Ferrara Ave., Wheaton, Md 20904					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE AUG. 10, 1987		23c. NAME OF CEMETERY OR CREMATORY Creveling Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bloomsburg COLUMBIA Pa.			
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE John F. Collins			
500 University Blvd., W. Silver Spring, Md. 20904									

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. The following carbon papers, Pages 1 and 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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062928 AUG 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23863

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA Feingold			2a. DATE OF DEATH MONTH DAY YEAR 8-11-87		2b. HOUR 1:45 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2-29 1893		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1412 BLAIR MILL RD. #20910								
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC GELB				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RIFKA PROPKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 068-32-4821		17. INFORMANT MRS. RUTH COOPER 3505 NORTHRIDGE DR. BALTO., MD 21208				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and pneumonia DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) uremia, congestive heart failure DUE TO OR AS A CONSEQUENCE OF (c) nephrosclerosis, arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 72 hrs 5 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension								
19a. DATE OF OPERATION 8-10-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1972 to 8-10 19 87 , that (I) (we) last saw the deceased alive on 8-10-87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John A. Galante MD				22c. DATE SIGNED 8-11-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Galante MD		
22e. ADDRESS 5225 POON HILL ROAD BETHESDA, MD 20854								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK		23d. LOCATION RANDALLSTOWN BALTO. MD DATE		
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

97
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward this permit to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 6 4
REG. NO.

FOR
STATE
REGISTRAR

063607 AUG 25 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it with the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed and within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		P M	
James		Beersford		Forman				August 20, 1987								4:00			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Male		White		October 10, 1906		80 YRS		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
New York		United States				Montgomery County													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Bethesda		5101 River Road, #1401		Industrial Analyst		Department of Commerce													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5101 River Road, #1401 / 20816											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
Alfred		G.		Forman		Julianna													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		577-58-8415		Eleanor M. Forman,		Same as 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Bladder Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>87</u> , to <u>August 20</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Aug 14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Frederick P. Smith</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Frederick P. Smith, M. D.		5401 Western Avenue, NW Washington, DC 20015																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Cremation		8-21-87		Metropolitan Crematory		Alexandria, Virginia													
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Richard Rapp, Inc. P. O. Box 43352, Washington, DC 20010		AUG 24 1987		<u>Frederick P. Smith</u>															

BP

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AUG 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23865

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Hazel

V.

Franyo

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

August 17, 1987

2:37PM

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

November 3, 1913

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

IF UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County MD.

10. CITY OR TOWN OF DEATH

Olney

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Montgomery General Hospital

12a. USUAL OCCUPATION

Merchandising

12b. KIND OF BUSINESS OR INDUSTRY

Retail

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

X NO ☐

13e. STREET ADDRESS / ZIP CODE

3535 Tarkington Lane/20906

14. FATHER'S NAME

George

MIDDLE

Parker

15. MOTHER'S MAIDEN NAME

Alma

Ruth

MIDDLE

Edmonds

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES ☐ OR UNKNOWN ☐ IF YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.

579-48-4036

17. INFORMANT

Donald S. Franyo

ADDRESS

12514 Pennyfield Lock Road, Potomac, MD 20854

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Adenocarcinoma of breast

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Several yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Diffuse bone involvement with hypercalcemia. Diffuse liver involvement with failure

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 17 Aug 19 87, that (I) (most) last saw the deceased alive on 17 Aug 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Donald E. Dillon

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

18 Aug 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Donald E. Dillon, M. D.

22e. ADDRESS

2901 Olney-Sandy Spring Road

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Aug. 20, 1987

23c. NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cemetery

23d. LOCATION

Sunshine, Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Robert A. Pumphrey

ADDRESS

Rockville, Inc. Funeral Home

25a. DATE REC'D. BY REGISTRAR

AUG 20 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

300 West Montgomery Ave. Rockville, MD

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84

(VIA 15, 4)

083348-0 AUG 51 87

100-100000

062866 AUG 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then, detach the funeral papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or a traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23800					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCY S. FRIEDLAND				2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10, 1987				2b. HOUR 6:30p M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 16, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WHEATON MANOR CARE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 903 ROSWELL DRIVE 20901	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM W. STEIBER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNY M. STOUFFER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (LIVES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577-24-1939		17. INFORMANT NIECE ADDRESS 353 WESTBURY DR RIVA, MARYLAND 21140	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diase</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8 Aug 87</u> to <u>10 August 1987</u> that (I) <u>last</u> saw the deceased alive on <u>8 Aug 87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did not) <u>see</u> the body after death.									
22b. SIGNATURE <u>Walter E. Goode</u> MD				22c. DATE SIGNED 11 Aug 87				22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOODE MD	
22e. ADDRESS 2309 SHOREFIELD ROAD WHEATON MD				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 15, 1987		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE MEYERSDALE PA			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE <u>John D. Borden</u>			

BP

082800 AUG 12 81

1

AUG 1 1981

063370 AUG 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23867

FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

GLADYS BAKAY FURLONG

7a. DATE OF DEATH

MONTH

DAY

YEAR

AUGUST 12 1987

7b. HOUR

6:30 P
M

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

March 8 1915

6. AGE (IN YEARS LAST BIRTHDAY)

72

YRS

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

PENNSYLVANIA

7b. CITIZEN OF WHAT COUNTRY?

UNITED STATES

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

NAVAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

HOME MAKER

12b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

VIRGINIA

13b. COUNTY

FAIRFAX

13c. CITY OR TOWN

MCLEAN

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS / ZIP CODE

7009 BENJAMIN STREET 22101

14. FATHER'S NAME

CHARLES RAYMOND BAKAY

15. MOTHER'S MAIDEN NAME

PEARL IDA DERR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

-

17. INFORMANT

ADDRESS

577-20-8456

WILLIAM R. FURLONG, JR., 7009 BENJAMIN STREET,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b)

UROSEPSIS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES

NO

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES

NO

21a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from AUGUST 8, 19 87, to AUGUST 12, 19 87, that (I) (we) lost

saw the deceased alive on AUGUST 12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR

STAFF PHYSICIAN

22c. DATE SIGNED

14 AUG 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

R. M. KEATING, LT, MC, USNR

22e. ADDRESS

NAVAL HOSPITAL
BETHESDA, MD 20814-5011

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

18 Aug 87

23c. NAME OF CEMETERY OR CREMATORY

Arlington National

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Arlington, Virginia

24. FUNERAL DIRECTOR NAME

MONEY & KING VIENNA FUNERAL HOME,

171 W. Maple Ave., Vienna, Va. 22180

25a. DATE REC'D. BY REGISTRAR

AUG 17 1987

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a cause of death.

003330 AUG 31 81

RECEIVED
FBI
AUG 31 1981

65474 SEP 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 3 8 6 8

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
JORGE HUMBERTO GAMEZ						8 31 19 87						7:39 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR			
MALE		WHITE		March 25, 1969		18 YRS.		MONTHS DAYS		HOURS MIN.		8 31 19 87		7:39 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Honduras				Honduras								Montgomery County MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS)				12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda				Suburban Hospital				Cashier				Food Store					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10900 Bucknell Dr. #632 20902			
Maryland				Montgomery				Wheaton									
4. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Eduardo Perez						Lidia Gamez											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
No						217-11-6316						Lidia Gamez same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:																	
8136 IMMEDIATE CAUSE (a) Cranio-cerebral trauma																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				6:40 P.M. 8-28-1987				Operator of bicycle/auto collision.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				road				Viers Mill Rd. & Georgia Ave., Montgomery, MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Ann M. Dixon, M.D.				M.D. Deputy Chief				MEDICAL EXAMINER				9-1-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				9/3/87		Gate of Heaven Cemetery				Silver Spring, Maryland							
24. FUNERAL DIRECTOR (NAME AND ADDRESS)																	
Pyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852																	
25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE					
SEP 14 1987												Julia Henderson-Rodriguez					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT (PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

02474 SEP 12 01

RECEIVED

SEP 12 1901

SEP 12 1901



90% COTTON

SEP 12 1901

Handwritten signature or initials.

SEP 14 1901
Handwritten text at the bottom of the page, including a date and possibly a name or address.

085215 AUG 13 01

POC COLON
DEIN
DIN

AUG 13 01

Void Death Certificate #87-23870



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2387

1. DECEASED NAME (TYPE OR PRINT) MARY Antoinette GIBALA				2a. DATE OF DEATH MONTH DAY YEAR 8 14 87				2b. HOUR 12:30^{AM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 26, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 12 14 30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Specialist		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7091 Catalpa Rd., 21701	
14. FATHER'S NAME FIRST MIDDLE LAST Rocco Leoni				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Mattea					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 393-01-3164		17. INFORMANT ADDRESS Gerald J. Gibala 11126 Dewey Rd., Kensington, Md. 20795					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE DAY YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CEREBRAL INFARCTION; HYPOXEMIC ENCEPHALOPATHY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 8/13 to 8/14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did not) view the body after death.									
22b. SIGNATURE Martin C. Shargel				DEGREE M.D.				22c. DATE SIGNED Aug. 14, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL				22e. ADDRESS 3720 FARAGUT AVE KENSINGTON, MD 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Port Myer, Arlington, Va.			
24. FUNERAL DIRECTOR NAME Smith, Keeney & Basford Funeral Home				24b. DATE RECD. BY REGISTRAR AUG 20 1987		24c. REGISTRAR'S NAME Richard A. ...			
106 East Church St., Frederick, Md. 21701									

BP

THE UNITED STATES OF AMERICA
 DEPARTMENT OF THE ARMY
 OFFICE OF THE CHIEF OF STAFF
 WASHINGTON, D. C. 20315

10 4
063253

AUG 20 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23872

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Abraham Gittleman</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>08 10 '87</i>		2b. HOUR <i>20:20 M</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>03 10 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75 yrs</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i>	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION <i>Inspector of Weights & Measures Dept.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>P. G. Gov't</i>
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Nathan Gittleman</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>(Unknown) (Unknown)</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>120-03-1247</i>		17. INFORMANT <i>Seymour Gittleman</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHRONIC OBSTRUCTIVE LUNG DISEASE, EMPHYSEMA, 10 YEARS SEVERE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <i>RECENT CEREBROVASCULAR ACCIDENT</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1</i> , 19 <i>87</i> , to <i>8/10</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/10</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Joseph B. Mizgerd, M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>8/11/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH B. MIZGERD, M.D.</i>		22e. ADDRESS <i>7600 CARROLL AVE. TAKOMA PARK, MD 20912</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8/14/1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Judean Mem. Gardens</i>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>Olney, Montgomery, Md.</i>					
24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25. DATE REC'D BY REGISTRAR <i>AUG 17 1987</i>		25. REGISTRAR'S SIGNATURE <i>John Gordon-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

003523 AUG 50 85

CONFIDENTIAL

063903 AUG 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23813

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK GOLDBERG			2a. DATE OF DEATH MONTH DAY YEAR 8-21-87		2b. HOUR MIN 3:50 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 12 1910		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS MINS 76
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MOVING CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY VAN-LINES
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY GOLDBERG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE BLOCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 577-03-7855		17. INFORMANT ADDRESS WIFE ROCKVILLE, MD 20852 ROSE GOLDBERG; 12000 OLD GEORGETOWN RD #1005-S		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Severe Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-24 19 84 , to 8-21 19 87 , that (I) (we) last saw the deceased alive on 8-21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Loreto S. Albioz, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-21-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Loreto S. ALBIOZ				22e. ADDRESS 6121 MONT. ROSE Rd.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/23/87		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GDNS		23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY MONTGOMERY MD
24. FUNERAL DIRECTOR'S NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE MD 20852				25a. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the funeral director within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

003003 YNG 52 81

YNG 52 81

064953 SEP - 9 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elena Gordillo			2a. DATE OF DEATH MONTH DAY YEAR 8-27-87			2b. HOUR 5:30 PM			
3. SEX FEMALE		4. RACE Hispanic		5. DATE OF BIRTH MONTH DAY YEAR 9 21 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mexico		7b. CITIZEN OF WHAT COUNTRY? Mexico		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1910 Locust Grove Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sprg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1910 Locust Grove Rd., 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caraupia Lopez					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Luz Carboney, Same as 13 above.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus, chronic anemia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-22-87 , 19 83 , to 8-27 , 19 87 , that (I) (we) last saw the deceased alive on 7-22-87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Kijak Jr MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Kijak Jr MD			22e. ADDRESS Prosperity Drive Silver Spring MD, 20904						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 30 AUG 87		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, PG, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS, INC., Silver Spring, MD				25a. DATE RECEIVED BY REGISTRAR SEP 8 1987		25b. REGISTRAR'S SIGNATURE Julia Dendron-Rodriguez			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an original physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2025

0638863 AUG 26 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DOROTHY E. GORDON		8 18 87		8 15		A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE	WHITE	MONTH DAY YEAR	76 YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
W. VA.	USA	Separated	MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING	SYLVAN MANOR		BOOKKEEPER				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
MD.	MONT.	S.S.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2307 PARKER AVE 20902			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Charles W. Bowen		Nona Pauly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
N/A		579-01-3370A		Patricia Passero-dau-2307 Parker Ave.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREbroVASCULAR ACCIDENT							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 9 MAY 19 87, to 17 AUG 19 87, that (we) last saw the deceased alive on 16 AUG 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
WALTER E. GOONH MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		17 AUG 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
WALTER E. GOONH MD				8309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		8-20-1987		Gate of Heaven		Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home Silver Spring, Md.				11800 N.H. ave.,		AUG 25 1987	

003888 100 20 01

005035 AUG 13 03

063307 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23877

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dora M. Gowen			2a. DATE OF DEATH MONTH DAY YEAR 8/16/87		2b. HOUR 7:50 A.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 22 1972		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Montgomery Bethesda				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS 4400 East West Highway 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Octavus Roy Cohen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Ottolengui			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-44-1158		17. INFORMANT ADDRESS 5002 Battery Lane Paul R. Gowen Bethesda, Maryland 20814			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION DUE TO, OR AS A CONSEQUENCE OF (b) DEPRESSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS MONTHS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c. HERPES ZOSTER							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 8/16, 19 87, that (II) (we) last saw the deceased alive on 8/15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
23a. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) RALPH M. COAN MD				23b. ADDRESS 4400 EAST WEST HIGHWAY BETHESDA, MD. 20814		23c. DATE SIGNED 8/16/87	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23e. DATE Aug. 19, 1987		23f. NAME OF CEMETERY OR CREMATORY Arlington National		23g. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814				25. DATE REC'D. BY REGISTRAR AUG 19 1987			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized pages and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23378

1. DECEASED NAME (TYPE OR PRINT) James Henry Graham, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 8/27/87		2b. HOUR 9:02PM M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 01/08/25		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lebanon, Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Draftsman		12b. KIND OF BUSINESS OR INDUSTRY Private Company
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Henry Graham, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy - Snavelly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1945-1948 577-30-6827		17. INFORMANT ADDRESS Charles D. Fultz (Cousin) Bethesda, MD 20816 4620-N. Chelsea Lane,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-1, 1987, to 8-27, 1987, that (I) (we) last saw the deceased alive on 8-26, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Tauber		DEGREE MD		22c. DATE SIGNED 8-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS 8718 Wisconsin Ave, Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 29, 1987		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, District of Columbia		23e. DATE RECEIVED BY REGISTRAR SEP 8 1987		23f. REGISTRAR'S SIGNATURE Julia Gordon-Randall	
24. FUNERAL DIRECTOR NAME ADDRESS J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove all burials prior to burial, cremation, or other disposition.

IMPORTANT: When 21 is marked either (a) when any injury, or other traumatic event, the medical examiner should be notified at once.

002042 SEP-81

UNITED STATES

SECTION 802

AMERICAN



SEP 8 - 81

063343 AUG 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23879
2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
8-16-87 12:20 AM

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy Marie Grant			2a. DATE OF DEATH MONTH DAY YEAR 8-16-87		2b. HOUR 12:20 AM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 22, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GEN CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES JORDON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET MAHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-46-7452	17. INFORMANT ADDRESS GRANDDAUGHTER 4520 ADRIAN STREET PATRICIA ROGERS ROCKVILLE, MD 20853		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: SP Stroke					
19a. DATE OF OPERATION 7/22, 7/28/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene both legs		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/21, 19 87, to 8/15, 19 87, that (I) (we) last saw the deceased alive on 8/15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Louis Korzoff		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Korzoff, M.D.		22e. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 18, 1987	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901		25a. DATE RECEIVED BY REGISTRAR AUG 20 1987			
25b. REGISTRAR'S SIGNATURE					

062346 AUG 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23830
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JANET GREENBERG			2a. DATE OF DEATH MONTH DAY YEAR AUG 5 87 5 45 PM		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 25 06	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		2b. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Retired)		12b. KIND OF BUSINESS OR INDUSTRY Milliner

13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6121 Montrose Road (20852)
14. FATHER'S NAME (FIRST) MIDDLE LAST Louis Markovitz			15. MOTHER'S MAIDEN NAME (FIRST) MIDDLE LAST Pepi Gluck			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 320-18-1884	17. INFORMANT ADDRESS Chevy Chase, Md. 20815 Gail G. Benensohn; Daughter; 7204 Maple Avenue;
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SENILE DEMENTIA DUE TO, OR AS A CONSEQUENCE OF (c) -----		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 HOURS 5 YEARS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CHRONIC LIVER DISEASE			
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
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22a. I certify that (he) (this hospital) attended the deceased from 4/2 19 85 to 8/5 19 87, that (he) (we) last saw the deceased alive on 8/5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE Steven Lipson	DEGREE MD	22c. DATE SIGNED 8/6/87
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN LIPSON	22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/7/87	23c. NAME OF CEMETERY OR CREMATORY Hillside Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Los Angeles, California
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24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	25a. DATE REC'D. BY REGISTRAR AUG 10 1987	25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

082346 NOV 11 81

THIST GREENBERG

Wm 2 22 04 81

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062952 AUG 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Alma MIDDLE: Griffin LAST: Griffin			2a. DATE OF DEATH MONTH: 8 DAY: 12 YEAR: 87 2b. HOUR: 5:30 AM			
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH: 7 DAY: 12 YEAR: 1928		
6a. BIRTHPLACE (STATE OR FOREIGN) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. IF UNDER 1 YEAR: MONTHS: DAYS: IF UNDER 24 HRS: HOURS: MIN.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE md			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST: STEWARD MIDDLE: LAST: MARY			15. MOTHER'S MAIDEN NAME FIRST: Lela MIDDLE: LAST: Haggard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-34-2118			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Diabetic Hyperosmolar Coma DUE TO, OR AS A CONSEQUENCE OF: (b): Sepsis DUE TO, OR AS A CONSEQUENCE OF: (c): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Arteriosclerotic Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 8/11/87 to 8/12/87, that (2) (we) last saw the deceased alive on 8/11/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.						
22b. SIGNATURE Peter Sherer		DEGREE MD		22c. DATE SIGNED 8/12/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer		22e. ADDRESS 3947 Ferrara Dr. Wheaton, md 20906				
23a. BURIAL, CREMATION, REMOVAL (S, C, F) Burial		23b. DATE 8-17-87		23c. NAME OF CEMETERY OR CREMATORY Kensalton		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME W. H. BACON		24b. ADDRESS 3947-14th		25a. DATE REC'D. BY REGISTRAR AUG 14 1987		
24c. NAME		24d. ADDRESS		25b. REGISTRAR'S SIGNATURE Julia Anderson-Rand		

MEDICAL CERTIFICATION

99

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-inhumation permit. Their plate remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

085025 AUG 12 85

REG. NO.

1 - FOR
- STATE
- REGISTRAR

062712 AUG 14 87

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
William L.		Grover Sr.		8 6 87		1632 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		09/18/20		66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Indiana		USA				Montgomery County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park,		Washington Adventist Hospital		Medical Technician hospital			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
13a. STATE Pennsylvania		13c. CITY OR TOWN Bedford		Route 1, Box 156-A, 15533			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Oscar J. Grover		Bertha Griffiee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WW II		310 01 7788		Marilyn Grover same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Cardiac-pulm arrest						5+ yrs	
Diabetes mellitus						20+ yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Jan 19 67, to Aug 6 19 87, that (I) (we) last saw the deceased alive on Aug 3 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE R.H. Sandstrom MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug 7 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.A. Sandstrom MD				22e. ADDRESS 7701 Carroll Ave Takoma Park, Md			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Aug. 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Cherry Lane Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE West Providence Twshp., Pa	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Home				ADDRESS Arlington, Va.		25a. DATE REC'D. BY REGISTRAR AUG 13 1987	
						25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be surrendered for use at the burial/transfer permit. Then please remove carbon papers. Page 3 (if it should be filed within 72 hours after death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

085215 AUG 14 85

10

AUG 14 1985

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 8 8 3
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice H. Guthrie			2a. DATE OF DEATH MONTH DAY YEAR Aug. 24, 1987		2b. HOUR 10:33^P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 19, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 60	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) # 5 Hesketh St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY MONT.		
13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE # 5 Hesketh St. 20815			14. FATHER'S NAME FIRST MIDDLE LAST Charles Webster Hartfield		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Lewis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		
16b. SOCIAL SECURITY NO. 427-38-3299			17. INFORMANT Annie H. Guthrie Same as item # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo.
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 8/19/87 to 8/24/87 that (we) last saw the deceased alive on 8/19/87 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE David W. SHERA, Jr. M.D.		DEGREE		22c. DATE SIGNED 8/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David W. SHERA, Jr. M.D.		22e. ADDRESS 5401 Westing Ave. NW, WDC 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-28-87	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION/ CITY OR TOWN COUNTY STATE Alexandria, VA	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.			25a. DATE REC'D. BY REGISTRAR AUG 31 1987		
ADDRESS 5130 WI Ave. NW Wash., DC 20016			25b. REGISTRAR'S SIGNATURE Gelia Davidson-Rodriguez		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of type.

01310 SEP-16

Address	City	State	Zip	Phone	Room	Rate	Remarks
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker
Montgomery	Dec. 19, 1958	White	Female	U.S.A.	7	10	Homemaker

1500 N. Ave. N. Wash., D.C. 20010
 Joseph W. Smith, Inc.
 Mt. Comfort Community, Alexandria, VA
 AUG 31 1959

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

062883 AUG 17 1987

FOR 1- STATE 17- REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		2 3 8 8 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARION HAZLEHURST HAGEN			2a. DATE OF DEATH MONTH DAY YEAR Aug. 10, 1987		2b. HOUR 6 55 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 11, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) So. Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL-BETHESDA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE SC	13b. COUNTY Charleston	13c. CITY OR TOWN Charleston	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 17 Rutledge Ave./29401	
14. FATHER'S NAME FIRST MIDDLE LAST George Edward Hazlehurst		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Marion Mikell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- --- ---	17. INFORMANT 17 Magnolia Pkwy. Jennie H. Boyd, Chevy Chase, MD 20815			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral Insufficiency</u>					
19a. DATE OF OPERATION <u>None</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 1985</u> to <u>present</u> 19 <u>87</u> tho (I) (we) lost saw the deceased alive on <u>Aug 7</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John B. Umkehr MD</u>		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/10/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John B. Umkehr MD</u>		22e. ADDRESS <u>8805 Conn. Ave., Chevy Chase Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>8/14/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Charleston, SC</u>		
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u>		24b. DATE REC'D. BY REGISTRAR <u>AUG 14 1987</u>		24c. REGISTRAR'S SIGNATURE <u>John B. Umkehr</u>	
25. ADDRESS <u>5130 Wisconsin Ave. NW, Washington, D.C. 20016</u>					

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AUG. 10, 1967

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AUG 14 1967

063079 AUG 19 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 8 8 5

1. DECEASED NAME (TYPE OR PRINT) LIGOURI Bernard HAGERTY, Jr.			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 16, 1987		2b. HOUR 0905AM
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR AUG 20 1932	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Military		12b. KIND OF BUSINESS OR INDUSTRY USAF
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN GLEN BURNIE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST LIGOURI BERNARD HAGERTY, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AUGUSTINE - WHEATLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean/VietNam 309-30-2187	17. INFORMANT (Wife) ADDRESS Glen Burnie, Md. CAROL S. HAGERTY 1460 GORDON DRIVE, 21061		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 13, 19 87, to AUGUST 16, 19 87, that (I) (we) last saw the deceased alive on AUGUST 16, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. P. Mehegan				22c. DATE SIGNED 17 Aug 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. MEHEGAN, LT, MC, USNR			22e. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND 20814-5011		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug 19, 1987	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery Ft. Myers		23d. LOCATION CITY OR TOWN COUNTY STATE VA.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home			25a. DATE REC'D. BY REGISTRAR AUG 18 1987		
ADDRESS Glen Burnie, Maryland			25b. REGISTRAR'S SIGNATURE Julia Davidson		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and place in the container with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked "other" or "not at work", the funeral director must obtain a copy of the death certificate from the hospital or attending physician.

063079 AUG 1981



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062718 AUG 14 87

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

2a. DATE OF DEATH MONTH DAY YEAR AUGUST 9 1987			2b. HOUR 8:45 P M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 28 1921	
6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD		10. CITY OR TOWN OF DEATH BETHESDA	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARTOGRAPHER		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Hamasian		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE Zakhig		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	
16b. SOCIAL SECURITY NO. 1942-1981		17. INFORMANT ADDRESS JULIA HAMASIAN, 8517 WILKESBORO LANE, POTOMAC, MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 3 19 87 to AUGUST 9 19 87, that (I) (we) last saw the deceased alive on AUGUST 9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. G. Litaker				22c. DATE SIGNED 8-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. G. LITAKER, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	
23d. LOCATION CITY OR TOWN Rockville		23e. COUNTY Maryland		23f. STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR AUG 13 1987	
25b. REGISTRAR'S SIGNATURE					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23337

1. DECEASED NAME (TYPE OR PRINT) Edna Bell Naudesty			2a. DATE OF DEATH MONTH DAY YEAR 8/3/87		2b. HOUR 9:37 PM	
3. SEX F		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4 25 15		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Cross Hosp		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Perdue Bell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mittie Moore		17. INFORMANT daughter ADDRESS 9140 Bryant Ave Laurel, MD 20707		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown		16b. SOCIAL SECURITY NO. 218-30-2988		17. INFORMANT Bonnie H. Mulvey		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Ovarian Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 4 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Liver metastases						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 8/3/87 to 8/4/87 that (2) (we) lost the deceased on 8/4/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (and) not view the body after death.						
22b. SIGNATURE Peter Sherer MD		DEGREE MD		22c. DATE SIGNED 8/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD		22e. ADDRESS 3947 Ferrara Dr. Wheaton MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		
23d. LOCATION (SPECIFY) Brentwood Prince Georges MD		23e. COUNTY MD		23f. STATE MD		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. W Silver Spring, MD 20901		25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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065066 SEP-987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23888

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH HAINES HARRISON			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 21 1987			2b. HOUR P M 8:50	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 12 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE DISTRICT OF COLUMBIA		13b. COUNTY NONE		13c. CITY OR TOWN NONE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3050 MILITARY ROAD, NW 20015		14. FATHER'S NAME FIRST MIDDLE LAST HERBERT COOPER SANFORD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA SHANNON HAINES		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -	
16a. SOCIAL SECURITY NO. 489-50-6975		17. INFORMANT ADDRESS LLOYD HARRISON, JR., 5711 OGDEN ROAD, BETHESDA,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENOCARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 27</u> , 19 <u>87</u> , to <u>AUGUST 21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. M. Keating</u> MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>24 AUG 87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. M. KEATING, MD, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9-8-1987		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARL. CO. VA.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

002000 SEP-80

SEP 8 1980
U.S. AIR FORCE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20330

062882 AUG 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE K LAST Harrison			2a. DATE OF DEATH MONTH DAY YEAR 8 8 87		2b. HOUR 12 35 A.M.
3. SEX F	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 27 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 y. 0	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE 30 Stoneygate In 3 Mont County		13b. COUNTY Silver Spring	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 30 Stoneygate Dr. SS. Md. 20904
14. FATHER'S NAME FIRST MARTIN MIDDLE KENNEDY LAST		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE ANNE LAST KENNY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO OR UNKNOWN <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 216-58-7522		17. INFORMANT ADDRESS ROSANNE HARRISON/DAUGHTER SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac anhy Humias. C.H.F.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>severe coronary artery disease -</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary artery insufficiency</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>sickle cell disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> 19 <u>87</u> to <u>8/7</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Joseph M. Salinas</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSEPH SALINAS		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 11, 1987	23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE BALTIMORE MD
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901		25. DATE REC'D. BY REGISTRAR AUG 14 1987			
25b. REGISTRAR'S SIGNATURE <u>Alia T. ...</u>					

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064352 SEP -1-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove responsibility. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23890
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IDA ALINE JOHNSON HATHAWAY		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 25, 1987		2b. HOUR 4:37 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 27, 1908	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FINLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 609 DEERFIELD AVENUE		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN JOHNSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA (UNKNOWN)		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-66-4500		17. INFORMANT ADDRESS HERBERT F. HATHAWAY, HUSBAND, SAME AS ITEM 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kidney failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>35 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 16, 1987</u> to <u>August 25, 1987</u> that (I) (we) last saw the deceased alive on <u>July 16, 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James F. McMurry, Jr.</u>				22c. DATE SIGNED AUGUST 27, 1987	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. McMurry, Jr.				22f. ADDRESS 6318 DEMOCRACY BLVD., BETHESDA, MD 20817	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-31-87		23c. NAME OF CEMETERY OR CREMATORY EAST CEMETERY	
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.		23d. LOCATION CITY OR TOWN COUNTY STATE PETERSHAM, MASSACHUSETTS		25. DATE REG'D. BY REGISTRAR AUG 31 1987	
P.O. BOX 43352, WASHINGTON, DC 20010		25. REGISTRAR'S SIGNATURE <u>John Gordon Foster</u>			

BP _____

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AUG 31 1987

0.64606 SEP-287

FOR
STATE
REGISTRAR.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2389

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ROBERT BRUCE HARTMAN			AUGUST 28 1987			3:18 A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE	CAUCASIAN	MONTH DAY YEAR APRIL 4, 1923	64 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
WEST VIRGINIA			UNITED STATES			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
BETHESDA			NAVAL HOSPITAL			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
WEST VIRGINIA			MARION			FAIRMONT		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. SOCIAL SECURITY NO.		
BRUCE			Hartman			ELsie		
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16c. SOCIAL SECURITY NO.			17. INFORMANT		
YES			1941-1945			235-30-3570		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a)			CARDIAC ARREST					
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) MYCOSIS FUNGOIDES					
DUE TO, OR AS A CONSEQUENCE OF			(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
21g. WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 13, 19 87, to AUGUST 28, 19 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 28, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
R. M. KEATING, LT, MC, USNR			MD			28 AUG 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
R. M. KEATING, LT, MC, USNR			NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Sept. 1, 1987			Pisgah Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE			23e. DATE REC'D. BY REGISTRAR					
Fairmont, West Virginia			SEP 1 - 1987					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814			SEP 1 - 1987			Julia Davidson-Randall		

004600 SEP-59



SEP 1 1959

064346 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please retain and complete pages 1 and 2, which should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.
IMPORTANT: If item 21 is marked by item 18 shows any injury, or other immediate cause of death, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="text-align: right;">2 3 8 9 2</div> <div style="text-align: right;">REG. NO.</div>									
1. DECEASED NAME (TYPE OR PRINT) BEULAH VIOLA HAWKINS					2a. DATE OF DEATH MONTH DAY YEAR AUGUST 25, 1987		2b. HOUR 8:05 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 18, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY Wash		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 719 SALEM AVE. 21740	
14. FATHER'S NAME FIRST MIDDLE LAST Emmett M. Jenkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Dennis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-24-5121		17. INFORMANT ADDRESS VIRGIL HAWKINS (HUSBAND) SAME AS PATIENT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>OVARIAN CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (K) (this hospital) attended the deceased from <u>JULY 19</u> , 19 <u>87</u> , to <u>AUGUST 25</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>AUGUST 25</u> , 19 <u>87</u> , and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <u>not</u> view the body after death.									
22b. SIGNATURE John Wright M.D.				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN WRIGHT				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-87		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Md.			
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 31 1987					

064346 SEP-1 87

Mar 1987

Honolulu

Donnie

Debbie

Junkins

M.

Enoch

No

064346

John Wright M.D.

John Wright

-27-07 Rose Hill Cemetery, Washington, D.C.

AUG 31 1987

John Wright Funeral Home, Inc.

061978 AUG - 8 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nellie B Hawkins			2a. DATE OF DEATH MONTH DAY YEAR 8-5-87		2b. HOUR 1:45 M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 6 / 17 / 18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE <input checked="" type="checkbox"/> 13b. COUNTY <input checked="" type="checkbox"/>			13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7308 Alaska Ave., NW / 20012
14. FATHER'S NAME FIRST MIDDLE LAST Hard Jefferson Dunbar			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ira Mae Thompson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-40-8186		17. INFORMANT ADDRESS Brin Hawkins 7308 Alaska Ave., NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Essential Hypertension - myocardial Infarct					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h 4 days 4 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus - hyperosmolar coma + multiple CVA's.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/11 , 19 70 , to 8/1 , 19 87 , that (I) (we) lost saw the deceased alive on 8/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE Max G. Sherer		DEGREE MD		22c. DATE SIGNED 8/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX G. SHERER, M.D.		22e. ADDRESS 800 Pershing Dr. Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/87		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		24. FUNERAL DIRECTOR NAME ADDRESS McGuire Funeral Service 7400 GA AVE Washington, DC			
25a. DATE REC'D BY REGISTRAR AUG 6 1987		25b. REGISTRAR'S SIGNATURE Julia Deaton-Randall			

DHMH - 16 60M 7/84
(VIA 15, 4)

081018 AUG-80

W. J. COLEMAN

W. J. COLEMAN

W. J. COLEMAN

W. J. COLEMAN

W. J. COLEMAN

062147 AUG 10 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23894

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY W. HAYNES			2a. DATE OF DEATH MONTH DAY YEAR 8-3-87		2b. HOUR 4 A.M.
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 5 1 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 82 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Worker		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12616 Epping Road 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Robert C. Haynes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence May Ball		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 226-01-5010		17. INFORMANT son James Haynes ADDRESS 3020 N. Dale Lane Bowie, MD 20716	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 87 , to 8/3 , 19 87 , that (I) (we) last saw the deceased alive on 7/31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W.C. Beane		DEGREE MD		22c. DATE SIGNED 8/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirkland C. Beane		22e. ADDRESS 1600 Carroll Ave - Takoma Park, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug 6, 1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont MD	
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901			25a. DATE REC'D BY REGISTRAR AUG 7 1987		
			25b. REGISTRAR'S SIGNATURE Julia Deaton-Randall		

MEDICAL CERTIFICATION

150

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1851 4 2 AUG 10 87

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				23895			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Thelma L. Heidkamp</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>8-23-1987</i>		2b. HOUR <i>10 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>January 1, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>89</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Continental</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Sparks</i>		13e. STREET ADDRESS / ZIP CODE <i>9808 Bristol Avenue 20901</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578-09-6813</i>		17. INFORMANT Brother-in-Law ADDRESS <i>Joseph Heidkamp, Sr. Sil Spr, MD 20901</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute cardiac degenerative atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11 MONTHS</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 22</i> 19 <i>87</i> , to <i>Aug 23</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>Aug 22</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN <i>Albert H. Grollman MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/23/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT H. GROLLMAN MD</i>				22e. ADDRESS <i>1106 SPRING ST. SILVER SPRING MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug 26, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Prince Georges MD</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>AUG 31 1987</i>			
500 University Blvd. W Silver Spring, MD 20901							

SEP 1 - 932 8 4 4 3

AUG 21 1932

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 5 9 0

1. FOR
STATE
REGISTRARDECEASED NAME
(PRINT)

FIRST

MIDDLE

LAST

MASON

August

HEIN

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
08-18-84 0039 AM3. SEX
MALE4. RACE
White5. DATE OF BIRTH
MONTH DAY YEAR
07 18 946. AGE (IN YEARS LAST BIRTHDAY)
93IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Illinois7b. CITIZEN OF WHAT COUNTRY?
U.S.A.8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD10. CITY OR TOWN OF DEATH
Takoma Park11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Agronomist12b. KIND OF BUSINESS OR INDUSTRY
Dept. of Agriculture

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland13b. COUNTY
Montgomery13c. CITY OR TOWN
Silver Spring13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS / ZIP CODE
8505 Springvale Road, #301

14. FATHER'S NAME

FIRST
WilliamMIDDLE
A.LAST
Hein

15. MOTHER'S MAIDEN NAME

FIRST
LivaMIDDLE
M.LAST
Cain

20910

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.
217-44-0518

17. INFORMANT

ADDRESS

Upper Hollow Road
Mason C. Hein (Son) Dorset, Vermont 0525118. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

20 minutes

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost

(b)

MYOCARDIAL INFARCTION

20 minutes

DUE TO, OR AS A CONSEQUENCE OF

(c)

ARTERIO SCLEROSIS OF VESSELS

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

SEVERE ISCHEMIA OF LEGS

19a. DATE OF OPERATION

8/17/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

ISCHEMIA OF LEGS

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/15 19 87 to 8/18 19 87, that (I) (we) lost
saw the deceased alive on 8/18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

8/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

GARRY D. RUBEN MD

22e. ADDRESS

11120 New Hamp Ave. Silver Spring, MD

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

08/20/87

23c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cemetery

23d. LOCATION
CITY OR TOWN

Brentwood

COUNTY

P.G. Maryland

24. FUNERAL DIRECTOR

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue Hyattsville, Maryland 20781

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

AUG 26 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition of the body.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other reason, medical examiner must be notified at once.

04015 AUG 50 81



AUG 50 81

063189 AUG 19 1987

Funeral Home 8-25-87
Film G630 DW

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion E. Hicks			2a. DATE OF DEATH MONTH DAY YEAR August 13, 1987		2b. HOUR 7:40 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1910		
6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oklahoma		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK, EXCEPT WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home		13. STREET ADDRESS / ZIP CODE 1003 North Mansion Drive 2608 Littleton St., 20910-20906		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Mattingly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude (unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Marshall Hicks-son- (same as 13c)		17. ADDRESS 12608 Littleton St. Wheaton, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>3/4 aneurysm of aorta</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>years</u> <u>years</u>						
19a. DATE OF OPERATION						
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7-10</u> , 19 <u>87</u> , to <u>8-14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Richard P. Delaney</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. DATE SIGNED 8/14/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, MD						
22e. ADDRESS 4323 Havard Street, Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						
23b. DATE 8-17-1987						
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery						
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.						
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.						
25a. DATE REC'D. BY REGISTRAR AUG 18 1987						
25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Rudman</u>						

MEDICAL CERTIFICATION

93-68-21-130

7-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

064484 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH23898
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Douglas Preston Hodge		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 8 DAY 31 YEAR 87 HOUR 6A	
3. SEX M	4. RACE Can	5. DATE OF BIRTH MONTH 4 DAY 6 YEAR 20	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10306 Royal Road Silver Spring MD	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
14. FATHER'S NAME FIRST Richard MIDDLE D. LAST Hodge		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Faulds LAST Faulds	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 579-12-4237	
17. INFORMANT Richard Hodge-son-Columbia, Md.		ADDRESS 8905 Early April Way 21046	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) none			
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? none	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) none			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul A. DeVore, MD		TITLE (SPECIFY) Deputy Medical Examiner	
EXAMINER'S NAME (TYPE OR PRINT) Paul A. DeVore, MD		DATE SIGNED 8-31-87	
ADDRESS 4203 GREENBURY RD HYATTVILLE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 4, 1987	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home ADDRESS 11800 N.H. Ave Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 1 1987	
25b. REGISTRAR'S SIGNATURE Lee Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10-PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 8 9 9

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR A M	
Mary Virginia Holman					August 22, 1987		4:45 A	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Female	White	April 26, 1942		45 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York	USA				Montgomery County MD.			
11. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	NIH, THE CLINICAL CENTER		Teacher		Hammond High			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN	13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f. STREET ADDRESS / ZIP CODE			
Maryland	Howard	Columbia			7039 Ivoryhand Place 21045			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS				
John P. Spanburgh		Helen Lenahan		Mr. Gordon D. Holman, husband same				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		050-34-7399						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic breast cancer								years
DUE TO, OR AS A CONSEQUENCE OF (c) Pleural effusions-bilateral								weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 10, 1984, to August 22, 1987, that (we) lost saw the deceased alive on August 22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.								
22b. SIGNATURE Richard Rosenberg MD						DEGREE		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8/22/87
22e. ADDRESS						National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		8/25/87		Meadowridge Cemetery		Elkridge Howard Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Harry H. Witzke Funeral Home Inc.		4112 Columbia Pike Ellicott City, Md. 21043		24 AUG 24 1987		Julie Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registrar, it should be filed in the funeral director's office. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23021 AUG 22 03

New York

USA

Teacher

Howard

John

W.

Spencer

Belin

John

Teacher

Serial

W/2707

Yonkers, N.Y. Cemetery

Location

Howard

Mr.

Harry N. Wicks Funeral

4112 Columbia Ave

Ellicott City, Md. 21037

Home Inc.

063164 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23900

1. DECEASED NAME (TYPE OR PRINT) ADELE MELBOURNE HOLMES			2a. DATE OF DEATH MONTH DAY YEAR 8-11-87			2b. HOUR 2200			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 2, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.			
13a. STATE ---			13b. COUNTY ---		13c. CITY OR TOWN Washington, DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Percival G. Melbourne			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite --- Chew						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS John H. Holmes, Same address as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ELECTRO-MECHANICAL DYSRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (b) ARRHYTHMIC SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) VENTRICULAR TACHYCARDIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: ISCHEMIC CARDIOMYOPATHY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/11 , 19 87 , to 8/11 , 19 87 , that (I) (we) last saw the deceased alive on 8/11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mark F. Weinstein				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark F. Weinstein MD				22e. ADDRESS 11125 Rockville Pike, Rockville, MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, MD			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 17 1987					
25b. REGISTRAR'S SIGNATURE 999999									

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked "a", item 21b shows any injury, or other traumatic event, the medical examiner must be notified at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

063184 AUG 19 97

Female	White	Aug. 2, 1908	79
Maryland	U.S.A.	X	
Secretary	Washington, DC	X	611 H Street, S.W. 20004
Perkins	G. Melbourne	Wagonerite	Chew
577-07-3491	John H. Holmes, same address as 15		

2130 Wisconsin Ave., Washington, D.C. 20016
 Joseph Fowler's Home, Inc.
 8/17/97
 Ft. Lincoln Cemetery
 Brentwood, MD
 11155 Rockville Pike, Rockville, MD 20852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or if a traumatic event, the medical examiner must be notified and an autopsy requested.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23901

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carole Thomsen Hoover			2a. DATE OF DEATH MONTH DAY YEAR August 3, 1987			2b. HOUR 10 A. M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 13, 1938		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 Hermleigh Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cust Repair Coord		12b. KIND OF BUSINESS OR INDUSTRY Case Comm	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thorvald Thomsen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Marie McCarthy		13e. STREET ADDRESS / ZIP CODE 502 Hermleigh Road 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-34-6234		17. INFORMANT Wallace A. Hoover/husband same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 1987, to Aug 3, 1987, that (I) (we) lost saw the deceased alive on July 30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Pamela Mulstane		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MULSTANE PAMELA		22e. ADDRESS 10500 SUMMIT AVENUE KENSINGTON, MD 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery MD	
24. FUNERAL DIRECTOR Francis J. Collins, Jr. NAME 500 University Blvd. W Silver Spring, MD 20901				25. DATE REC'D. BY REGISTRAR AUG 14 1987			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

065002 JUN 12 03



065002 JUN 12 03

062072 AUG - 8 07

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 9 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maxwell B. Hope			2a. DATE OF DEATH MONTH DAY YEAR August 2, 1987		2b. HOUR 2:07p M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 21, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY General Contracting
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Damasus	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 28309 Kemptown Rd. 20872	
14. FATHER'S NAME FIRST MIDDLE LAST Randall Sayer Hope			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Malcolm Banister		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 236-32-3492		17. INFORMANT (Wife) ADDRESS Grace L. Hope Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordine Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypercalcemia DUE TO, OR AS A CONSEQUENCE OF (c) metastatic Cancer of lung Squamous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 4 weeks 18 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 86 to Aug 2 1987 that (I) (we) last saw the deceased alive on Aug 2 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Oliver James Lawless M.D.				22c. DATE SIGNED 8-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OLIVER JAMES LAWLESS				22e. ADDRESS 18111 Prince Philip Drive Olney Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 05, 1987	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumfrey ADDRESS 300 West Montgomery Ave., Rockville, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 06 1987		
			25b. REGISTRAR'S SIGNATURE Julia Bender-Rudner		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

085055 AUG-80

085055 AUG-80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 23403

1- STATE
REGISTER

REG. NO.

1 DECEASED NAME (LAST, FIRST, MIDDLE) RAE W. HOROWITZ		2a DATE OF DEATH MONTH DAY YEAR 8/28/87		2b HOUR 2:15 PM	
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Aug. 6, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 89	
7a BIRTHPLACE (STATE OR FOREIGN) New Jersey		7b CITIZEN OF WHAT COUNTRY? USA		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employee	
12b KIND OF BUSINESS OR INDUSTRY Government		13a STATE Maryland		13b COUNTY Montgomery	
13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 9727 Mount Pisgah Road 20903	
14 FATHER'S NAME FIRST MIDDLE LAST Louis Waller		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Unknown		16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/> N/A	
16b SOCIAL SECURITY NO. 577 84 5308		17 INFORMANT Louis Horowitz same as #13		18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HISTORY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f LOCATION STREET CITY OR TOWN COUNTY STATE		22a I certify that (I) (the undersigned) attended the deceased from Aug 2 19 87 to present 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.		22b DATE SIGNED 8/28/87	
22c PHYSICIAN'S NAME (TYPE OFFICIAL) John Merindino		22d ADDRESS Rockville, Md.		22e DEGREE MD	
22f ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23a BURIAL, CREMATION, REMOVAL Burial		23b DATE Aug. 30 1987	
23c NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d LOCATION Adelphi, Maryland		23e STATE Md.	
24 FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes		24b ADDRESS Falls Church, Va. 22046		25a DATE REC'D. BY REGISTRAR SEP 02 1987	
25b REGISTRAR'S SIGNATURE Julia Burden					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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084637 SEP-381

20% COLUMBIAN PAPER

THE NEW YORK



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064240 AUG 31 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23904
REG. NO.

1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) Albert J. Hoskinson		2a. DATE OF DEATH MONTH DAY YEAR Aug. 21, 1987		2b. HOUR 6:30A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1895	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 92	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill-Silver Spring		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Capt.		12b. KIND OF BUSINESS OR INDUSTRY USCG		13a. STREET ADDRESS / ZIP CODE 4402 Fessenden St. NW	
13a. STATE DC		13b. COUNTY N/A		13c. CITY OR TOWN Wash.	
14. FATHER'S NAME FIRST MIDDLE LAST W. H. Hoskinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. 579-56-4635		17. INFORMANT Charles A. Shortt		ADDRESS Hilton Head Island, SC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 6/21/87 , 19____, to 8/21/87 , 19____, that (I) (we) last saw the deceased alive on 7/26/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Jerry A. Snow</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 21, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jerry A. Snow		22e. ADDRESS 4900 Mass. Ave, NW, Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/87		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, MD		24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016			
25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the person certifying the death be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by a certifying physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please enclose this page with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified of this.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

064240 Aug 31 81

Albert	5.	Washington	1000
Male	White	June 6, 1965	1000
NS	U.S.A.	x	Montgomery
Silver Spring	Carrage Hill-Silver Spring	Oct.	1000
DC	W.A.	x	4405 Pennsylvania St. NW
W.	H.	Washington	(Unknown)
W. I	375-24-455	Marion A. Shortt Hilton Hotel, 80	

Aug. 21, 1967

4000 Mass. Ave, NW, Washington, D.C.

Joseph A. Snow

Joseph A. Snow, Inc.

2130 Wisconsin Ave., NW, Washington, D.C. 20007

Aug 28 1967

062906 AUG 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23905
REG NO

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY C. HOYLE			2a. DATE OF DEATH MONTH DAY YEAR 8 10 87			2b. HOUR 3 PM	
3. SEX M		4. RACE W I		5. DATE OF BIRTH MONTH DAY YEAR 5 31 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Surveyor		12b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST William L. Hoyle, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Josephine C. Hoyle		ADDRESS Wife Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinson's Disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-23 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10301 Georgia Ave. Silver Spring, Md. 20902		21g. DATE SIGNED 8-10-87	
22. I certify that (I) (this hospital) attended the deceased from 8-10-87 to 8-10-87 , that (I) (we) last saw the deceased alive on 8-10-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did) (did not) see the body after death.							22e. ADDRESS
22a. SIGNATURE Carroll D. Mahoney, M.D.				22b. PHYSICIAN'S NAME (TYPE OR PRINT) Carroll D. Mahoney, M.D.		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE John Benson-Randall	
25c. ADDRESS 500 University Blvd., W. Silver Spring, Md. 20901							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completed, the funeral director, page 3, should be detached for use as the burial transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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VME 15 81

062457 AUG 12 07

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 3 9 0 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Betty Wen-Juan Hsu			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 8 87 19			2b. HOUR 9 58 P M									
3. SEX Female		4. RACE Oriental		5. DATE OF BIRTH MONTH DAY YEAR 1 25 57		6. AGE (IN YEARS) (LAST BIRTHDAY) 36 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 8 87 19		7d. HOUR 10 43 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Taiwan				7b. CITIZEN OF WHAT COUNTRY? China				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13900 Mustang Hill Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13900 Mustang Hill Lane/20878					
14. FATHER'S NAME FIRST MIDDLE LAST Show Feng Lin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Way May											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None				17. INFORMANT ADDRESS Paul Y.F. Hsu Same as #13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HANGING</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>John Tauber</u>				TITLE (SPECIFY) <u>Deputy</u>				MEDICAL EXAMINER <u>Bethesda Md.</u>				DATE SIGNED <u>8-9-87</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tauber</u>				ADDRESS <u>8218 Wisconsin Ave</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE August 14, 1987				23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Md. 20814				25a. DATE REC'D BY REGISTRAR AUG 11 1987				25b. REGISTRAR'S SIGNATURE <u>C. L. Davidson</u>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH BORN, PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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63677 AUG 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23907

1. DECEASED NAME (TYPE OR PRINT) John W. Hudson			2a. DATE OF DEATH MONTH DAY YEAR August 18, 1987			2b. HOUR 2:20pm			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 8, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		8b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL NURSING HOME OR OTHER INSTITUTION Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drag Line Operator		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Florida				13b. CITY OR TOWN Apopka		13c. STREET ADDRESS / ZIP CODE 855 Hollow Branch Road 32703			
14. FATHER'S NAME FIRST MIDDLE LAST George W. Hudson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 261-28-0099		17. INFORMANT Mrs. Agnes P. Costin 21 West Fillmore Avenue Orlando, Florida 32809/(Daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Surgery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Abdominal aortic aneurysm</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>									
19a. DATE OF OPERATION <u>8-18-87</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Abdominal aortic aneurysm</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>8-17-87</u> to <u>8-18-87</u> , that (1) (we) last saw the deceased alive on <u>8-17-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael J. Salkin</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8-18-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Salkin</u>				22e. ADDRESS <u>18111 Price Philip Dr Olney Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>August 22, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Apopka, Florida</u>			
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey</u> ADDRESS <u>300 W. Montgomery Ave. Rockville, Maryland 20850</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 24 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

Released By: Dr. John M. Tauber, Deputy Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

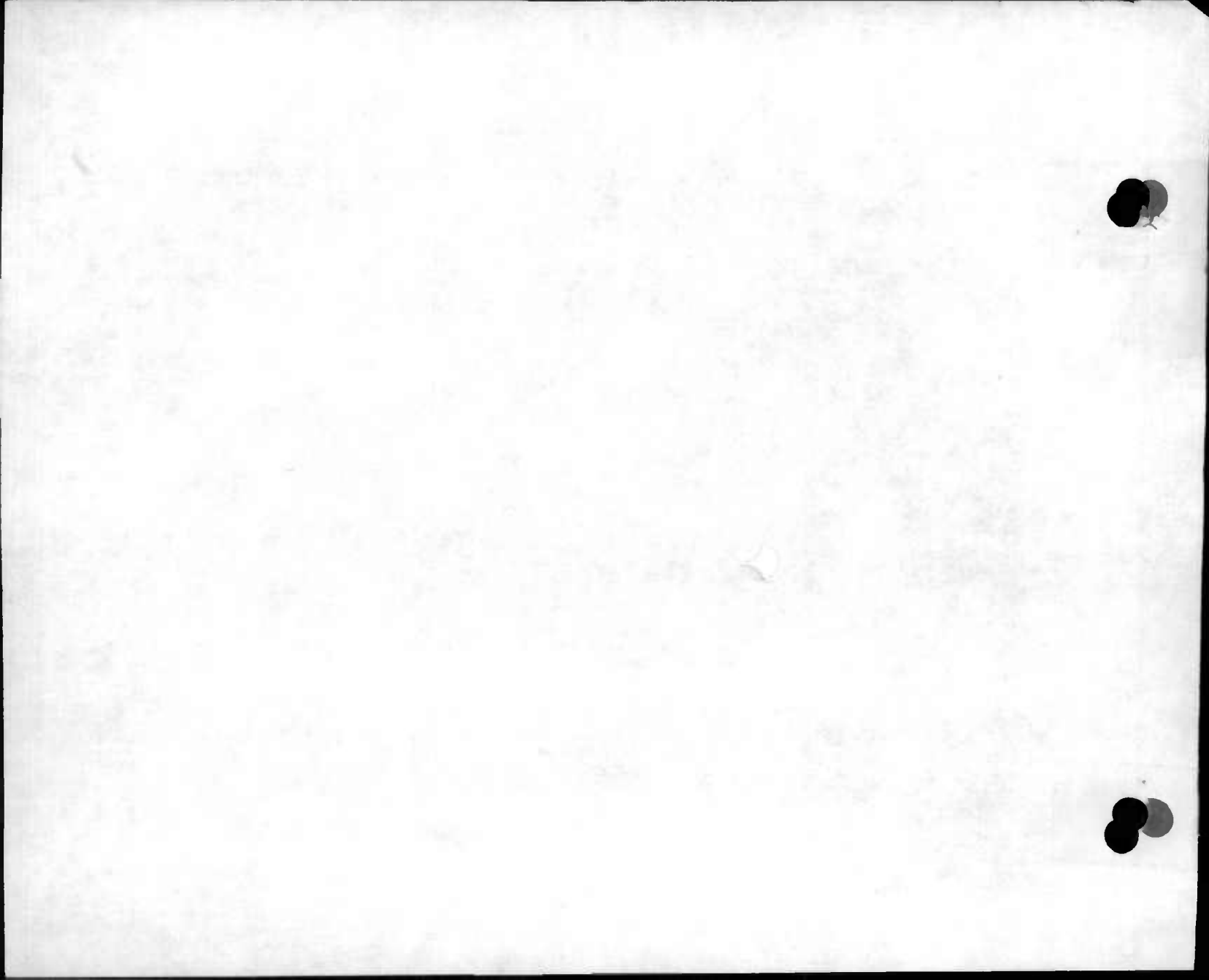
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked "other," show any injury, or other traumatic event, the medical examiner must be notified at once.

03011 AUG 22 01

COLLON

Void Death Certificate #87-23908



065241 SEP 14 1987

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23909
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT) Gayle Sandra Houston			2a. DATE KNOWN OF DEATH ESTIMATED Aug 16 1987			2b. HOUR M											
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Dec 23 37 49		6. AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD Aug 26 1987		2d. HOUR P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			7. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH D.C.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1220 East West Hwy Apt 616						12a. USUAL OCCUPATION (TYPE OF WORK) Computer Specialist			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Montg			13c. CITY OR TOWN D.C.			13d. INSIDE (CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1220 East West Hwy Apt 616					
14. FATHER'S NAME (TYPE OR PRINT) William Clarence Houston Jr.			15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Rosa P. Montgomery			16. SOCIAL SECURITY NO. 379-52-6818						17. INFORMANT Margaret Ledick			ADDRESS 3221 Berwyn Ave. Annapolis, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE J. Rogers			TITLE (SPECIFY) M.D. Dep			MEDICAL EXAMINER			DATE SIGNED Aug 24 1987								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation			23b. DATE 8/29/87			23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory			23d. LOCATION (CITY OR TOWN) COUNTY STATE Washington, D.C.								
24. FUNERAL DIRECTOR (TYPE OR PRINT) St. Ernest Korman Co. Inc.			ADDRESS 1432 U St NW			25a. DATE RECD. BY REGISTRAR SEP 04 1987			25b. REGISTRAR'S SIGNATURE [Signature]								

022541 256 14 81

20% COTTON FIBER

UNITED STATES OF AMERICA



1652582 SEP 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4, remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23910

1. DECEASED NAME (TYPE OR PRINT) PATRICIA F. HUGHES			2a. DATE OF DEATH MONTH DAY YEAR 8-31-87		2b. HOUR 2243
3. SEX F	4. RACE C White	5. DATE OF BIRTH MONTH DAY YEAR 12 11 28		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE MD		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Seward Funk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Patterson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 169-24-0186		17. INFORMANT ADDRESS Mrs. Frances H. Glendening-University Park, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) central nervous system hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) multiple myeloma DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Martin Weltz DEGREE W				22c. DATE SIGNED 9-1-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Weltz				22e. ADDRESS 525 Greenway G. Orme Greenbelt	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09-03-1987	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany MD
24. FUNERAL DIRECTOR NAME ADDRESS James F. Scarpelli, Cumberland, MD 21502				25. DATE RECEIVED BY REGISTRAR SEP 08 1987	

MEDICAL CERTIFICATION

002222 924 10

063399

AUG 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23911

1. DECEASED NAME (TYPE OR PRINT) MINNIE E. IAZETTI			2a. DATE OF DEATH MONTH DAY YEAR 8-11-87			2b. HOUR 8 ³⁰ A M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-1-1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Dept & Grocer Stores		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Hyman Patlen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Berman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-20-4009		17. INFORMANT ADDRESS Janet E. Feldberg 8713 Leonard Drive, Silver Spring, Md. 20910						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC ORGANIC BRAIN SYNDROME DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) CEREBROVASCULAR ISCHEMIA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONGESTIVE HEART FAILURE; SENILE INANITION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/10/87 June 12, 1982 to Aug 4, 1987, that (I) (we) last above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Martin C. Shargel				DEGREE M.D.				22c. DATE SIGNED 8/11/1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL, M.D.				22e. ADDRESS 3720 FALLACUT AVE KENSINGTON, MD - 20895						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/1987		23c. NAME OF CEMETERY OR CREMATORY National Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia				
24. DONALD H. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR AUG 17 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall		

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

003300 AUG 51 81

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 1 2

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) Nellie Polley Jackson			2a. DATE OF DEATH MONTH DAY YEAR Aug. 12, 1987		2b. HOUR 12:30P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8100 Beech Tree Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Agent-Northwestern Life		12b. KIND OF BUSINESS OR INDUSTRY Mutual
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Mont.	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Oliver Polley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leora Hughes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 303-10-0408		17. INFORMANT ADDRESS Indianapolis, IN Carolyn J. Kimberlin P.O. Box 68012	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma liver</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Adeno Carcinoma Cecum & Right Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Right Colon</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i> <i>4-5 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION <i>6/4/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Obstruction Right Colon</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/17</i> , 19 <i>86</i> , to <i>8/12</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>7/24</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>J. Blaine Fitzgerald</i>					22c. DATE SIGNED <i>8/13/87</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald					22e. ADDRESS 8218 Wisconsin Ave, Bethesda, MD 20814
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/17/87		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Greenwood, IN		24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016			
25a. DATE REC'D. BY REGISTRAR AUG 17 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

063182 AUG 1907

15:30P JACKSON POLLEY HELLIE

AUG. 17, 1907

Female White Dec. 11, 1904 85

Montgomery U.S.A. x

Bethesda 8100 Beech Tree Road Special Agent-Montgomery

Mont. Bethesda x 8100 Beech Tree Rd. 20817

James Oliver Polley Leona

305-10-0403 Carolyn L. Timberlin P.O. Box 68012 Indianapolis, IN

x

x

1. Blake Street 8518 Wisconsin Ave, Bethesda, MD 20814

Greenwood Inn Greenwood Inn

Joseph Lawler's Sons, Inc. 5730 Wisconsin Ave, Washington, D.C. 20016

065033 SEP 9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 23, show any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23913
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Virginia Anne Jenkins			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1987			2b. HOUR 2:03PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 16, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Darnestown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15708 Bondy Lane 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Philip Spencer Edgar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wortley Blanche Ranson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-76-8473		17. INFORMANT ADDRESS Anne Jenkins Bird same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Age									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1980, to 8/30, 1987, that (I) (we) last saw the deceased alive on 8/3, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE Ronald E. Greger, M.D.								22c. DATE SIGNED Aug. 31, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald E. Greger, M.D.				22e. ADDRESS 15001 Dufief Mill Road Gaithersburg, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 1, 1987		23c. NAME OF CEMETERY OR CREMATORY Woodland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ashland Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD. 20814				25a. DATE REC'D BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

002035 SEP-81

SEP 8 1981

063192 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2391

1. DECEASED NAME (TYPE OR PRINT) NAFSIKA JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR 8/18/87			2b. HOUR 3:45 A.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Bethesda		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN Bethesda					17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
18. FATHER'S NAME FIRST MIDDLE LAST Vasili Papavasiliou					19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Paraskevoula Denopoulos				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 577 40 2588A		17. INFORMANT ADDRESS Roger Hays (Son in law) Same as 13E					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UROSEPSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic breast carcinoma								10 years	
DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic heart disease								1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ILEUS, ANEMIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/3 , 19 87 , to 8/18 , 19 87 , that (I) (we) last saw the deceased alive on 8/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. S. Kanovsky				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN S. KANOVSKY				22e. ADDRESS 5401 Western Ave. NW, Washington DC.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 18 1987 Julia Gordon-Rader					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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064888-SEP-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div style="text-align: right;">23915</div> <div style="text-align: center;">FOR STATE REGISTRAR</div>										
1. DECEASED NAME (TYPE OR PRINT) T HELMA R JOHNSTON					2a. DATE OF DEATH MONTH 08 DAY 31 YEAR 87					2b. HOUR 0206 M
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 9 DAY 13 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		7b. IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Insurance Co.		
13a. STATE Maryland					13b. COUNTY Prince Geo.		13c. CITY OR TOWN Lewisdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST John MIDDLE LAST King					15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE LAST Suppes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-03-4694		17. INFORMANT ADDRESS Roy C. Johnston (husband) Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke-cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from June 19 85 to Aug 19 87 , that (I) (we) lost saw the deceased alive on Aug 30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Boris Rabkin MD					DEGREE MD			22c. DATE SIGNED 8-31-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORIS RABKIN MD					22e. ADDRESS 1019 Union Blvd EGA Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 09/03/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Geo. MD				
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. ADDRESS 4739 Baltimore Ave. Hyattsville, MD 20781					25a. DATE REC'D. BY REGISTRAR SEP 4 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rabkin			

004888-26-881



063697

AUG 25 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23916
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Tillie Karasik			2a. DATE OF DEATH MONTH DAY YEAR Aug. 17, 1987			2b. HOUR 6:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9 W. Lenox Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Mendel Teplitz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosamund Bovley			13e. STREET ADDRESS / ZIP CODE 9 W. Lenox Street/20815			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 086-10-1305		17. INFORMANT ADDRESS Monroe Karasik, Same address as #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIO PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CONGESTING HEART FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-17 19 86 , to 8-17 19 87 , that (I) (we) last saw the deceased alive on 8-17 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marvin Fuchs				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Aug. 18, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin Fuchs				22e. ADDRESS 5315 Conn. Ave., NW, Washington, D.C. 20015					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/19/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

MEDICAL CERTIFICATION

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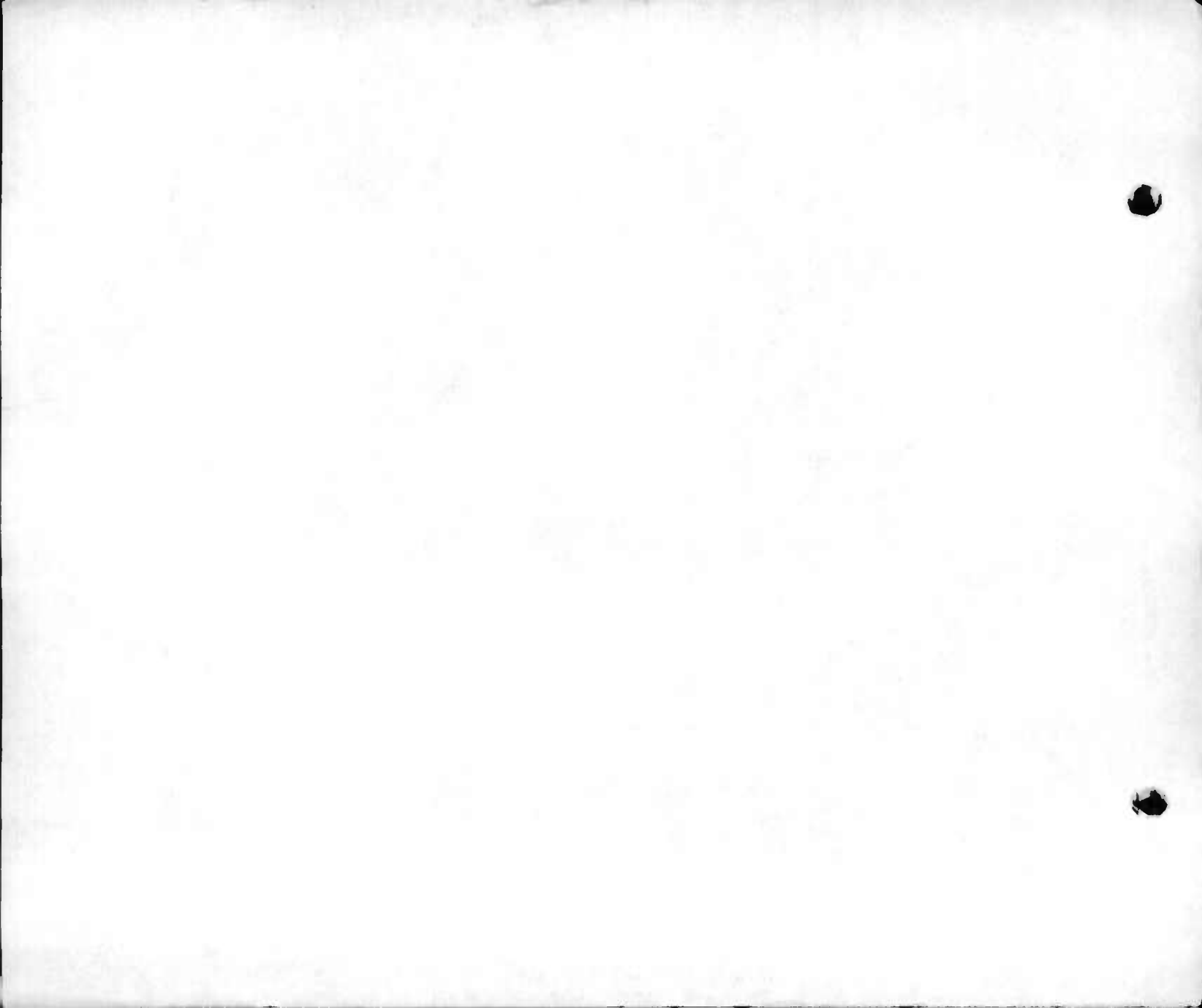
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic or infirm medical condition, a medical examiner must be notified at once.

VOID DEATH CERTIFICATE NUMBER ---23917



063498

AUG 24 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23918

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Michael L. Keefe			2a. DATE OF DEATH MONTH DAY YEAR 08 17 87			2b. HOUR 1:25AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 19, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dir. of Security		12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Off.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Keefe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariah (unavailable)			13e. STREET ADDRESS / ZIP CODE 6 Pinebrook Ct. 20904		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] no		16b. SOCIAL SECURITY NO. 215-44-8414		17. INFORMANT ADDRESS Daughter - Eileen Bonhag - Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Exophytic Neoplasm of Neck DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Larynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 4 mo. 25 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1987, to Aug. 17, 1987, that (I) (we) last saw the deceased alive on Aug. 16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Frank J. Mayo				DEGREE MD		22c. DATE SIGNED 8-17-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Mayo				22e. ADDRESS 16220 Frederick Rd. #213 Guthrieburg, Md. 20877				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 20'87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR NAME James J. DeVol				ADDRESS DeVol Funeral Home Washington, D.C.		25a. DATE REC'D. BY REGISTRAR AUG 21 1987		
				25b. REGISTRAR'S SIGNATURE John A. [Signature]				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

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May 10, 1961

White

Male

U.S.A.

White

x

Dir. of Security U.S. Post Off.

67-10-1000

x

Miss Mary Jane

Montgomery

Miss Mary Jane

(unavailable)

Marshall

Michael Keefe

67-10-1000 - Silver Spring - Lake as 67

no

Miss Mary Jane

Montgomery

Miss Mary Jane

Miss Mary Jane

Level General Home

Washington, D.C.

062151 AUG 10 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 9 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA M. Keely			2a. DATE OF DEATH MONTH DAY YEAR 8 - 3 - 87			2b. HOUR 8:35 A.M.			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1 11 99		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Albertus E. Warner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Kimmelman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 219-54-9628			17 INFORMANT Susan A. Poling			ADDRESS 114 Sunnyside Rd. Silver Spring, MD 20910			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 5 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive Heart Failure - Chronic Lung Disease (Old Tuberculosis)</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/1 19 87 to 8/3 19 87, that (I) (we) last saw the deceased alive on 8/2 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.									
23a. SIGNATURE Carl I. Schoenberg						DEGREE MD		23c. DATE SIGNED 8/13/87	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) Carl I. Schoenberg						23d. ADDRESS 4701 Randolph Rd Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia		
24 FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins, Jr. 500 University Blvd., W Silver Spring, MD 20901						25a. DATE REC'D BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

BP

065121 AUG 10 94

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8

REG. NO. 23920

063376 AUG 27 1987

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST ROSEMARIE P. KELLEHER		AUGUST 15, 1987		1:37AM	
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 4 19 05	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY MONT.	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DENIS F. KELLEHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN MAHONEY		13e. STREET ADDRESS / ZIP CODE 3314 CHISWICK CT. 20906	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 140-28-1483	17. INFORMANT ADDRESS COUSIN ROCKVILLE, MD. FRANCIS COYLE 4601 GREAT OAK RD. 20853		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Probable Pre-Leukemic state Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) marked myeloproliferative Disorder APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) S/P Carcinoma Rt. Breast w/ Radiation					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cardiac Arrhythmia		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/27, 19 87, to 8/19/ 19 87 that (I) last saw the deceased alive on 8/19/ 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gustavo S. Belaval, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 AUG 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gustavo S. Belaval		22e. ADDRESS Leisure World Medical Center Silver Spring, Md 20905			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE AUG 16, 1987		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN ALEXANDRIA		COUNTY VA.		STATE	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS JR.		SILVER SPRING, MD. ADDRESS 500 University Blvd.W.		25a. DATE REC'D BY REGISTRAR AUG 20 1987	
25b. REGISTRAR'S SIGNATURE					

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Item 16a, Film G631 9-24-87 dw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 9 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
JOHN		R.H.		KELLY, Sr.				0824		19		87		17		43	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Caucasian	02 19 16		71 YRS.						08 24 19		87		17		43	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
New Mexico		United States		WIDOWED		DIVORCED		MONTGOMERY County, MD									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BETHESDA		SUBURBAN HOSPITAL		Safety Engineer		A.E.C.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		MONTGOMERY		ROCKVILLE		YES		311 W. EDMONSTON DR									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
John		P.H. Kelly		221 10 6893		Marie P. Kelly		Same as #13.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				GUNSHOT WOUND HEAD				ACUTE									
				(b) DEPRESSION				INDEF									
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		1658 P.M. 08 24 1987		SHOT HIMSELF IN MOUTH. 22 CAL.													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		HOME		311 W. EDMONSTON DR ROCKVILLE MONT MD													
22a. I certify that I took charge of the remains described above, held on death resulted from:																	
Natural Causes Accident Suicide Homicide Undetermined manner																	
Autopsy Inspection Inquiry and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
FRANCIS C MAYLE		M.D. DEPT				8/24/87											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
FRANCIS C MAYLE		8200 W. SCOTLAND AVE BETHESDA															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		28, 1987		Gate of Heaven Cemetery		Silver Spring		Maryland									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert A. Pumphrey Funeral Home/ Rockville, Inc.		AUG 31 1987		Julia Davidson-Ross													
300 West Montgomery Ave. Rockville, Maryland																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 10M-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpse cap, tag 1, and 2, and place them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or anatomical donation. Tag 1 should be retained by the funeral director. Tag 2 should be retained by the State Dept. of Health and Mental Hygiene. Tag 3 should be retained by the funeral director. Tag 4 should be retained by the funeral director. Tag 5 should be retained by the funeral director. Tag 6 should be retained by the funeral director. Tag 7 should be retained by the funeral director. Tag 8 should be retained by the funeral director. Tag 9 should be retained by the funeral director. Tag 10 should be retained by the funeral director. Tag 11 should be retained by the funeral director. Tag 12 should be retained by the funeral director. Tag 13 should be retained by the funeral director. Tag 14 should be retained by the funeral director. Tag 15 should be retained by the funeral director. Tag 16 should be retained by the funeral director. Tag 17 should be retained by the funeral director. Tag 18 should be retained by the funeral director. Tag 19 should be retained by the funeral director. Tag 20 should be retained by the funeral director. Tag 21 should be retained by the funeral director. Tag 22 should be retained by the funeral director. Tag 23 should be retained by the funeral director. Tag 24 should be retained by the funeral director. Tag 25 should be retained by the funeral director. Tag 26 should be retained by the funeral director. Tag 27 should be retained by the funeral director. Tag 28 should be retained by the funeral director. Tag 29 should be retained by the funeral director. Tag 30 should be retained by the funeral director. Tag 31 should be retained by the funeral director. Tag 32 should be retained by the funeral director. Tag 33 should be retained by the funeral director. Tag 34 should be retained by the funeral director. Tag 35 should be retained by the funeral director. Tag 36 should be retained by the funeral director. Tag 37 should be retained by the funeral director. Tag 38 should be retained by the funeral director. Tag 39 should be retained by the funeral director. Tag 40 should be retained by the funeral director. Tag 41 should be retained by the funeral director. Tag 42 should be retained by the funeral director. Tag 43 should be retained by the funeral director. Tag 44 should be retained by the funeral director. Tag 45 should be retained by the funeral director. Tag 46 should be retained by the funeral director. Tag 47 should be retained by the funeral director. Tag 48 should be retained by the funeral director. Tag 49 should be retained by the funeral director. Tag 50 should be retained by the funeral director. Tag 51 should be retained by the funeral director. Tag 52 should be retained by the funeral director. Tag 53 should be retained by the funeral director. Tag 54 should be retained by the funeral director. Tag 55 should be retained by the funeral director. Tag 56 should be retained by the funeral director. Tag 57 should be retained by the funeral director. Tag 58 should be retained by the funeral director. Tag 59 should be retained by the funeral director. Tag 60 should be retained by the funeral director. Tag 61 should be retained by the funeral director. Tag 62 should be retained by the funeral director. Tag 63 should be retained by the funeral director. Tag 64 should be retained by the funeral director. Tag 65 should be retained by the funeral director. Tag 66 should be retained by the funeral director. Tag 67 should be retained by the funeral director. Tag 68 should be retained by the funeral director. Tag 69 should be retained by the funeral director. Tag 70 should be retained by the funeral director. Tag 71 should be retained by the funeral director. Tag 72 should be retained by the funeral director. Tag 73 should be retained by the funeral director. Tag 74 should be retained by the funeral director. Tag 75 should be retained by the funeral director. Tag 76 should be retained by the funeral director. Tag 77 should be retained by the funeral director. Tag 78 should be retained by the funeral director. Tag 79 should be retained by the funeral director. Tag 80 should be retained by the funeral director. Tag 81 should be retained by the funeral director. Tag 82 should be retained by the funeral director. Tag 83 should be retained by the funeral director. Tag 84 should be retained by the funeral director. Tag 85 should be retained by the funeral director. Tag 86 should be retained by the funeral director. Tag 87 should be retained by the funeral director. Tag 88 should be retained by the funeral director. Tag 89 should be retained by the funeral director. Tag 90 should be retained by the funeral director. Tag 91 should be retained by the funeral director. Tag 92 should be retained by the funeral director. Tag 93 should be retained by the funeral director. Tag 94 should be retained by the funeral director. Tag 95 should be retained by the funeral director. Tag 96 should be retained by the funeral director. Tag 97 should be retained by the funeral director. Tag 98 should be retained by the funeral director. Tag 99 should be retained by the funeral director. Tag 100 should be retained by the funeral director.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23922

1. DECEASED NAME (TYPE OR PRINT) Wayne Maurice Kemper			2a. DATE OF DEATH MONTH DAY YEAR August 18, 1987		2b. HOUR 3:15 P _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 21 1940	6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist - Science Technology	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9706 Montauk Ave, 20817
14. FATHER'S NAME FIRST MIDDLE LAST Maurice Kemper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Romaine Shank			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Mrs. Vonnice M. Kemper, wife same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF THE ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (b) PLEURAL EFFUSIONS DUE TO, OR AS A CONSEQUENCE OF (c) ASCITES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 15, 1986, to August 18, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 18, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN EVANS MD		22e. ADDRESS National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Aug. 22, 1987	23c. NAME OF CEMETERY OR CREMATORY Emanuel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lewisherry Pennsylvania	
24. FUNERAL DIRECTOR NAME Ives Pearson Funeral Homes		ADDRESS Arlington, Va.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry Leslie King									
2a. DATE OF DEATH MONTH DAY YEAR 8 11 87		2b. HOUR 120 A.M.							
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 15 37		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		15. KIND OF BUSINESS OR INDUSTRY Construction	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 5109 Russett Rd / 20853					
19. FATHER'S NAME FIRST MIDDLE LAST Henri C. King		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Dunn Stevenson							
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		21b. SOCIAL SECURITY NO. 1956-1962		22. INFORMANT (Wife) Shirley Ann King		23. ADDRESS Same as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute Coronary, lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> 19 <u>87</u> to <u>8/10</u> 19 <u>87</u> , that (I) (we) lost saw the deceased <u>alive</u> on <u>8/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edgar H. Levin</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED August 11, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edgar H. Levin, M.D.		22e. ADDRESS 20902 9801 Georgia Ave #341 Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey, Inc. 300 West Montgomery Ave. Rockville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE <u>via David R. Pumphrey</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23924
REG. NO.

1. FOR
STATE
REGISTRAR

2a. DECEASED NAME (TYPE OR PRINT) Ruth P Kirby		2b. DATE OF DEATH MONTH DAY YEAR 8-9-87		2c. HOUR 2:23P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 18, 1899	
6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? United States	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		10. CITIZEN OF WHAT COUNTRY? United States		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		16. COUNTY County		17. CITY OR TOWN Rockville	
18. FATHER'S NAME FIRST MIDDLE LAST Evan Gaither		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Murphy		20. STREET ADDRESS / ZIP CODE 199 Rollins Avenue / 20852	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -		22. SOCIAL SECURITY NO. 214-28-7537		23. INFORMANT Mr. Parker T. Kirby, Son, 7716 Warbler Lane, Derwood, MD. 20855	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular arrhythmias</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>GI bleeding, gangrene R foot</u>					
26. DATE OF OPERATION 7/29/87		27. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene R foot		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		33. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE	
35. I certify that (I) (this hospital) attended the deceased from 8/21, 1987, to 8/9, 1987, that (II) (we) lost above the deceased alive on 8/9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (I) (did) (did not) view the body after death.					
36. SIGNATURE Louis Korloff MD				37. DATE SIGNED 8/10/87	
38. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Korloff, MD				39. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD 20814	
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE August 12, 1987		42. NAME OF CEMETERY OR CREMATORY Union Cemetery	
43. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ 300 W. Montgomery Ave., Rockville, MD. 20850		44. DATE REC'D. BY REGISTRAR AUG 13 1987		45. REGISTRAR'S SIGNATURE James D. ...	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

2 3 9 2 5

062872 AUG 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other illness, the medical examiner must be notified.

FOR
STATE
REGISTRAR

per funeral home

1. DECEASED NAME (TYPE OR PRINT) JEAN T. Kissinger			2a. DATE OF DEATH MONTH DAY YEAR 8-7-87			2b. HOUR 3:48 M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 4 26		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Manor care MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPRVISOR D.C. DEPT OF FINANCE			
13a. STATE md				13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Greatorcy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY M. WALTERS				13e. STREET ADDRESS / ZIP CODE 1208 Milton St 20902	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-24-3841		17. INFORMANT ADDRESS JOHN R. KISSINGER/HUSBAND SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma Multiforme DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION 7/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Crematory for brain tumor				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 7/30 19 87 to 8/7 19 87 , that (we) last saw the deceased alive on 7/30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.									
22b. SIGNATURE Peter Sherer				DEGREE MD				22c. DATE SIGNED 8/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD				22e. ADDRESS 3947 Ferrara Dr. Wheaton MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 10, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 9 2 0
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Goodwin Kiff		2a. DATE KNOWN OF DEATH MONTH DAY YEAR Aug 8 1987		2b. HOUR 32
3. SEX F	4. RACE Blk	5. DATE OF BIRTH MONTH DAY YEAR March 24 1967	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. MONTHS DAYS 19	7. IF UNDER 1 YR. MONTHS DAYS 19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH St. Sp.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress
13a. STATE MD		13b. CITY OR TOWN St. Sp.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Toliver		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dodson		16. SOCIAL SECURITY NO. 578-22-0010
17. INFORMANT ADDRESS Bennie Goodwin (husband) same as item #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None				
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE John P. Rogers		TITLE (SPECIFY) M.D.		DATE SIGNED Aug 8, 1987
EXAMINER'S NAME (TYPE OR PRINT) John P. Rogers		ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-13-87		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park
23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.		24. FUNERAL DIRECTOR ADDRESS Vann & Williams, 4804 Ga. Ave., N.W., Wash., D.C.		
DATE REC'D. BY REGISTRAR AUG 12 1987		25. REGISTRAR'S SIGNATURE Julia Davidson-Landover		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1000.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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063945 AUG 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23927
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERNARD B. KLINE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 21 1987		2b. HOUR 0700
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 6 12		6. AGE (IN YEARS LAST BIRTHDAY) 75	
7a. BIRTHPLACE (STATE OR FOREIGN) PA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Pharmacy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13e. STREET ADDRESS / ZIP CODE 2310 Peggy Lane (20910)		
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Kline		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Nathan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----	17. INFORMANT ADDRESS Ruth Kline Wife; 2310 Peggy Lane; Silver Spring Maryland 20910			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	(b) interstitial lung disease and bronchopneumonia	3 weeks
	(c) lymphoma	5 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/7 1987 to 8/21 87 , that (I) (we) last saw the deceased alive on 8/19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Bruce A. Silver, MD		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A. Silver, MD		22e. ADDRESS 106 Irving St., N.W., Wash. DC 20010			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/23/87	23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn.; Falls Church; Fairfax; Va.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852			25a. DATE REC'D. BY REGISTRAR AUG 26 1987
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

TO PROBATE COURT: If item 21 is checked on Form 34-1, either one traumatic or other traumatic against the medical examiner must be filed with the probate court.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

2 3 4 2 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Melville</i>		MIDDLE <i>Stanley</i>		LAST <i>Knox</i>		2. DATE OF DEATH MONTH DAY YEAR <i>8/26/87</i>		2b. HOUR <i>0650</i>	
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>November 20, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>85</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD</i>					
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adv. Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Rep.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Manufacturing</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>82 Anna Court / 20877</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Not Available</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Not Available</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>028 01 8222</i>		17. INFORMANT ADDRESS <i>82 Anna Court</i> <i>Ms. Delores M. Knox Gaithersburg, Md. 20877</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>renal failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>dehydration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>urinary tract infection; debility</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <i>August 25</i> , 19 <i>87</i> , to <i>August 26</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>August 25</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (I) (we) (d) the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8/26/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen Vaccarella</i>				22e. ADDRESS <i>8246 Montrose Rd Rockville Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>August 28, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Montgomery Crematorium</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bethesda Maryland</i>					
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Funeral Home/</i> <i>Rockville, Inc.</i> <i>300 West Montgomery Ave. Rockville, Maryland</i>						25. DATE REC'D. BY REGISTRAR <i>AUG 31 1987</i>					

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AUG 31 1967

062432 AUG 12, 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23929
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST TAMARA	MIDDLE KOMINIC	LAST KOMINIC	2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10 1987		2b. HOUR 2:35 A M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 2 1947		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MARYLAND				13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN BOWIE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY JOHN KOMINIC				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA BETH KIRKLAND				13e. STREET ADDRESS / ZIP CODE 12124 LONGRIDGE LANE 20715
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - 213-54-6543		17. INFORMANT ADDRESS STANLEY J. KOMINIC, 12124 LONGRIDGE LANE, BOWIE, MD 20715				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>prader willi syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 27</u> 19 <u>87</u> , to <u>AUGUST 10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Edward P. Fox</u>				DEGREE M.D.		22c. DATE SIGNED 10 Aug 87		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD P. FOX, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND 20814-5011				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE AUG 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Beall Funeral Home		ADDRESS 16000 Annapolis Road Bowie, MD 20715-3043		25a. DATE REC'D. BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE <u>J. L. Swiden-Rondo</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, figures, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 states any injury or other traumatic event, the medical examiner must be notified promptly.

BP

RECEIVED

(100)

Company

W/A

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W/A

064198 AUG 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 3 9 3 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Rudolf F. J.			MIDDLE Korade			LAST Korade			2a. DATE KNOWN OF DEATH MATED			2b. DATE PRONOUNCED DEAD			2c. DATE PRONOUNCED DEAD			2d. DATE PRONOUNCED DEAD			2e. DATE PRONOUNCED DEAD			2f. DATE PRONOUNCED DEAD			2g. DATE PRONOUNCED DEAD			2h. DATE PRONOUNCED DEAD			2i. DATE PRONOUNCED DEAD			2j. DATE PRONOUNCED DEAD			2k. DATE PRONOUNCED DEAD			2l. DATE PRONOUNCED DEAD			2m. DATE PRONOUNCED DEAD			2n. DATE PRONOUNCED DEAD			2o. DATE PRONOUNCED DEAD			2p. DATE PRONOUNCED DEAD			2q. DATE PRONOUNCED DEAD			2r. DATE PRONOUNCED DEAD			2s. DATE PRONOUNCED DEAD			2t. DATE PRONOUNCED DEAD			2u. DATE PRONOUNCED DEAD			2v. DATE PRONOUNCED DEAD			2w. DATE PRONOUNCED DEAD			2x. DATE PRONOUNCED DEAD			2y. DATE PRONOUNCED DEAD			2z. DATE PRONOUNCED DEAD																																																																																																																																																																																																														
3. SEX			4. RACE			5. DATE OF BIRTH (MONTH DAY YEAR)			6. AGE (IN YEARS) (LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			9. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			10. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			11. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			12. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			13. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			14. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			15. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			16. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			17. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			18. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			19. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			20. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			21. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			22. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			23. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			24. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			25. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			26. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			27. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			28. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			29. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			30. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			31. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			32. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			33. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			34. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			35. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			36. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			37. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			38. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			39. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			40. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			41. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			42. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			43. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			44. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			45. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			46. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			47. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			48. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			49. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			50. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			51. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			52. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			53. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			54. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			55. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			56. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			57. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			58. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			59. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			60. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			61. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			62. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			63. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			64. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			65. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			66. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			67. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			68. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			69. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			70. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			71. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			72. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			73. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			74. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			75. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			76. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			77. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			78. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			79. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			80. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			81. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			82. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			83. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			84. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			85. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			86. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			87. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			88. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			89. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			90. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			91. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			92. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			93. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			94. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			95. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			96. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			97. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			98. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			99. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			100. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WH. COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. BALTIMORE CITY OR COUNTY OF DEATH			11. BALTIMORE CITY OR COUNTY OF DEATH			12. BALTIMORE CITY OR COUNTY OF DEATH			13. BALTIMORE CITY OR COUNTY OF DEATH			14. BALTIMORE CITY OR COUNTY OF DEATH			15. BALTIMORE CITY OR COUNTY OF DEATH			16. BALTIMORE CITY OR COUNTY OF DEATH			17. BALTIMORE CITY OR COUNTY OF DEATH			18. BALTIMORE CITY OR COUNTY OF DEATH			19. BALTIMORE CITY OR COUNTY OF DEATH			20. BALTIMORE CITY OR COUNTY OF DEATH			21. BALTIMORE CITY OR COUNTY OF DEATH			22. BALTIMORE CITY OR COUNTY OF DEATH			23. BALTIMORE CITY OR COUNTY OF DEATH			24. BALTIMORE CITY OR COUNTY OF DEATH			25. BALTIMORE CITY OR COUNTY OF DEATH			26. BALTIMORE CITY OR COUNTY OF DEATH			27. BALTIMORE CITY OR COUNTY OF DEATH			28. BALTIMORE CITY OR COUNTY OF DEATH			29. BALTIMORE CITY OR COUNTY OF DEATH			30. BALTIMORE CITY OR COUNTY OF DEATH			31. BALTIMORE CITY OR COUNTY OF DEATH			32. BALTIMORE CITY OR COUNTY OF DEATH			33. BALTIMORE CITY OR COUNTY OF DEATH			34. BALTIMORE CITY OR COUNTY OF DEATH			35. BALTIMORE CITY OR COUNTY OF DEATH			36. BALTIMORE CITY OR COUNTY OF DEATH			37. BALTIMORE CITY OR COUNTY OF DEATH			38. BALTIMORE CITY OR COUNTY OF DEATH			39. BALTIMORE CITY OR COUNTY OF DEATH			40. BALTIMORE CITY OR COUNTY OF DEATH			41. BALTIMORE CITY OR COUNTY OF DEATH			42. BALTIMORE CITY OR COUNTY OF DEATH			43. BALTIMORE CITY OR COUNTY OF DEATH			44. BALTIMORE CITY OR COUNTY OF DEATH			45. BALTIMORE CITY OR COUNTY OF DEATH			46. BALTIMORE CITY OR COUNTY OF DEATH			47. BALTIMORE CITY OR COUNTY OF DEATH			48. BALTIMORE CITY OR COUNTY OF DEATH			49. BALTIMORE CITY OR COUNTY OF DEATH			50. BALTIMORE CITY OR COUNTY OF DEATH			51. BALTIMORE CITY OR COUNTY OF DEATH			52. BALTIMORE CITY OR COUNTY OF DEATH			53. BALTIMORE CITY OR COUNTY OF DEATH			54. BALTIMORE CITY OR COUNTY OF DEATH			55. BALTIMORE CITY OR COUNTY OF DEATH			56. BALTIMORE CITY OR COUNTY OF DEATH			57. BALTIMORE CITY OR COUNTY OF DEATH			58. BALTIMORE CITY OR COUNTY OF DEATH			59. BALTIMORE CITY OR COUNTY OF DEATH			60. BALTIMORE CITY OR COUNTY OF DEATH			61. BALTIMORE CITY OR COUNTY OF DEATH			62. BALTIMORE CITY OR COUNTY OF DEATH			63. BALTIMORE CITY OR COUNTY OF DEATH			64. BALTIMORE CITY OR COUNTY OF DEATH			65. BALTIMORE CITY OR COUNTY OF DEATH			66. BALTIMORE CITY OR COUNTY OF DEATH			67. BALTIMORE CITY OR COUNTY OF DEATH			68. BALTIMORE CITY OR COUNTY OF DEATH			69. BALTIMORE CITY OR COUNTY OF DEATH			70. BALTIMORE CITY OR COUNTY OF DEATH			71. BALTIMORE CITY OR COUNTY OF DEATH			72. BALTIMORE CITY OR COUNTY OF DEATH			73. BALTIMORE CITY OR COUNTY OF DEATH			74. BALTIMORE CITY OR COUNTY OF DEATH			75. BALTIMORE CITY OR COUNTY OF DEATH			76. BALTIMORE CITY OR COUNTY OF DEATH			77. BALTIMORE CITY OR COUNTY OF DEATH			78. BALTIMORE CITY OR COUNTY OF DEATH			79. BALTIMORE CITY OR COUNTY OF DEATH			80. BALTIMORE CITY OR COUNTY OF DEATH			81. BALTIMORE CITY OR COUNTY OF DEATH			82. BALTIMORE CITY OR COUNTY OF DEATH			83. BALTIMORE CITY OR COUNTY OF DEATH			84. BALTIMORE CITY OR COUNTY OF DEATH			85. BALTIMORE CITY OR COUNTY OF DEATH			86. BALTIMORE CITY OR COUNTY OF DEATH			87. BALTIMORE CITY OR COUNTY OF DEATH			88. BALTIMORE CITY OR COUNTY OF DEATH			89. BALTIMORE CITY OR COUNTY OF DEATH			90. BALTIMORE CITY OR COUNTY OF DEATH			91. BALTIMORE CITY OR COUNTY OF DEATH			92. BALTIMORE CITY OR COUNTY OF DEATH			93. BALTIMORE CITY OR COUNTY OF DEATH			94. BALTIMORE CITY OR COUNTY OF DEATH			95. BALTIMORE CITY OR COUNTY OF DEATH			96. BALTIMORE CITY OR COUNTY OF DEATH			97. BALTIMORE CITY OR COUNTY OF DEATH			98. BALTIMORE CITY OR COUNTY OF DEATH			99. BALTIMORE CITY OR COUNTY OF DEATH			100. BALTIMORE CITY OR COUNTY OF DEATH											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY			14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. CITY OR TOWN			16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			17. STREET ADDRESS			18. CITY OR TOWN			19. STATE			20. COUNTY			21. CITY OR TOWN			22. STATE			23. COUNTY			24. CITY OR TOWN			25. STATE			26. COUNTY			27. CITY OR TOWN			28. STATE			29. COUNTY			30. CITY OR TOWN			31. STATE			32. COUNTY			33. CITY OR TOWN			34. STATE			35. COUNTY			36. CITY OR TOWN			37. STATE			38. COUNTY			39. CITY OR TOWN			40. STATE			41. COUNTY			42. CITY OR TOWN			43. STATE			44. COUNTY			45. CITY OR TOWN			46. STATE			47. COUNTY			48. CITY OR TOWN			49. STATE			50. COUNTY			51. CITY OR TOWN			52. STATE			53. COUNTY			54. CITY OR TOWN			55. STATE			56. COUNTY			57. CITY OR TOWN			58. STATE			59. COUNTY			60. CITY OR TOWN			61. STATE			62. COUNTY			63. CITY OR TOWN			64. STATE			65. COUNTY			66. CITY OR TOWN			67. STATE			68. COUNTY			69. CITY OR TOWN			70. STATE			71. COUNTY			72. CITY OR TOWN			73. STATE			74. COUNTY			75. CITY OR TOWN			76. STATE			77. COUNTY			78. CITY OR TOWN			79. STATE			80. COUNTY			81. CITY OR TOWN			82. STATE			83. COUNTY			84. CITY OR TOWN			85. STATE			86. COUNTY			87. CITY OR TOWN			88. STATE			89. COUNTY			90. CITY OR TOWN			91. STATE			92. COUNTY			93. CITY OR TOWN			94. STATE			95. COUNTY			96. CITY OR TOWN			97. STATE			98. COUNTY			99. CITY OR TOWN			100. STATE																							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			19. CITY OR TOWN			20. STATE			21. COUNTY			22. CITY OR TOWN			23. STATE			24. COUNTY			25. CITY OR TOWN			26. STATE			27. COUNTY			28. CITY OR TOWN			29. STATE			30. COUNTY			31. CITY OR TOWN			32. STATE			33. COUNTY			34. CITY OR TOWN			35. STATE			36. COUNTY			37. CITY OR TOWN			38. STATE			39. COUNTY			40. CITY OR TOWN			41. STATE			42. COUNTY			43. CITY OR TOWN			44. STATE			45. COUNTY			46. CITY OR TOWN			47. STATE			48. COUNTY			49. CITY OR TOWN			50. STATE			51. COUNTY			52. CITY OR TOWN			53. STATE			54. COUNTY			55. CITY OR TOWN			56. STATE			57. COUNTY			58. CITY OR TOWN			59. STATE			60. COUNTY			61. CITY OR TOWN			62. STATE			63. COUNTY			64. CITY OR TOWN			65. STATE			66. COUNTY			67. CITY OR TOWN			68. STATE			69. COUNTY			70. CITY OR TOWN			71. STATE			72. COUNTY			73. CITY OR TOWN			74. STATE			75. COUNTY			76. CITY OR TOWN			77. STATE			78. COUNTY			79. CITY OR TOWN			80. STATE			81. COUNTY			82. CITY OR TOWN			83. STATE			84. COUNTY			85. CITY OR TOWN			86. STATE			87. COUNTY			88. CITY OR TOWN			89. STATE			90. COUNTY			91. CITY OR TOWN			92. STATE			93. COUNTY			94. CITY OR TOWN			95. STATE			96. COUNTY			97. CITY OR TOWN			98. STATE			99. COUNTY			100. CITY OR TOWN																	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			19. CITY OR TOWN			20. STATE			21. COUNTY			22. CITY OR TOWN			23. STATE			24. COUNTY			25. CITY OR TOWN			26. STATE			27. COUNTY			28. CITY OR TOWN			29. STATE			30. COUNTY			31. CITY OR TOWN			32. STATE			33. COUNTY			34. CITY OR TOWN			35. STATE			36. COUNTY			37. CITY OR TOWN			38. STATE			39. COUNTY			40. CITY OR TOWN			41. STATE			42. COUNTY			43. CITY OR TOWN			44. STATE			45. COUNTY			46. CITY OR TOWN			47. STATE			48. COUNTY			49. CITY OR TOWN			50. STATE			51. COUNTY			52. CITY OR TOWN			53. STATE			54. COUNTY			55. CITY OR TOWN			56. STATE			57. COUNTY			58. CITY OR TOWN			59. STATE			60. COUNTY			61. CITY OR TOWN			62. STATE			63. COUNTY			64. CITY OR TOWN			65. STATE			66. COUNTY			67. CITY OR TOWN			68. STATE			69. COUNTY			70. CITY OR TOWN			71. STATE			72. COUNTY			73. CITY OR TOWN			74. STATE			75. COUNTY			76. CITY OR TOWN			77. STATE			78. COUNTY			79. CITY OR TOWN			80. STATE			81. COUNTY			82. CITY OR TOWN			83. STATE			84. COUNTY			85. CITY OR TOWN			86. STATE			87. COUNTY			88. CITY OR TOWN			89. STATE			90. COUNTY			91. CITY OR TOWN			92. STATE			93. COUNTY			94. CITY OR TOWN			95. STATE			96. COUNTY			97. CITY OR TOWN			98. STATE			99. COUNTY			100. CITY OR TOWN																																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			19. CITY OR TOWN			20. STATE			21. COUNTY			22. CITY OR TOWN			23. STATE			24. COUNTY			25. CITY OR TOWN			26. STATE			27. COUNTY			28. CITY OR TOWN			29. STATE			30. COUNTY			31. CITY OR TOWN			32. STATE			33. COUNTY			34. CITY OR TOWN			35. STATE			36. COUNTY			37. CITY OR TOWN			38. STATE			39. COUNTY			40. CITY OR TOWN			41. STATE			42. COUNTY			43. CITY OR TOWN			44. STATE			45. COUNTY			46. CITY OR TOWN			47. STATE			48. COUNTY			49. CITY OR TOWN			50. STATE			51. COUNTY			52. CITY OR TOWN			53. STATE			54. COUNTY			55. CITY OR TOWN			56. STATE			57. COUNTY			58. CITY OR TOWN			59. STATE			60. COUNTY			61. CITY OR TOWN			62. STATE			63. COUNTY			64. CITY OR TOWN			65. STATE			66. COUNTY			67. CITY OR TOWN			68. STATE			69. COUNTY			70. CITY OR TOWN			71. STATE			72. COUNTY			73. CITY OR TOWN			74. STATE			75. COUNTY			76. CITY OR TOWN			77. STATE			78. COUNTY			79. CITY OR TOWN			80. STATE			81. COUNTY			82. CITY OR TOWN			83. STATE			84. COUNTY			85. CITY OR TOWN			86. STATE			87. COUNTY			88. CITY OR TOWN			89. STATE			90. COUNTY			91. CITY OR TOWN			92. STATE			93. COUNTY			94. CITY OR TOWN			95. STATE			96. COUNTY			97. CITY OR TOWN			98. STATE			99. COUNTY			100. CITY OR TOWN																																						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 yrs.</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			22b. TITLE (SPECIFY) M.D. <u>Dep.</u> MEDICAL EXAMINER			22c. DATE SIGNED Aug 24 1987			22d. ACTUAL SIGNATURE JOHN S. ROGERS			22e. ADDRESS 1919 SEMINARY Rd. S.S. Md.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			24. FUNERAL DIRECTOR NAME ADDRESS W.W. CHAMBERS CO. INC. SILVER SPRING, MD.			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			26. DATE REC'D. BY REGISTRAR			26b. REGISTRAR'S SIGNATURE			27. DATE REC'D. BY REGISTRAR			27b. REGISTRAR'S SIGNATURE			28. DATE REC'D. BY REGISTRAR			28b. REGISTRAR'S SIGNATURE			29. DATE REC'D. BY REGISTRAR			29b. REGISTRAR'S SIGNATURE			30. DATE REC'D. BY REGISTRAR			30b. REGISTRAR'S SIGNATURE			31. DATE REC'D. BY REGISTRAR			31b. REGISTRAR'S SIGNATURE			32. DATE REC'D. BY REGISTRAR			32b. REGISTRAR'S SIGNATURE			33. DATE REC'D. BY REGISTRAR			33b. REGISTRAR'S SIGNATURE			34. DATE REC'D. BY REGISTRAR			34b. REGISTRAR'S SIGNATURE			35. DATE REC'D. BY REGISTRAR			35b. REGISTRAR'S SIGNATURE			36. DATE REC'D. BY REGISTRAR			36b. REGISTRAR'S SIGNATURE			37. DATE REC'D. BY REGISTRAR			37b. REGISTRAR'S SIGNATURE			38. DATE REC'D. BY REGISTRAR			38b. REGISTRAR'S SIGNATURE			39. DATE REC'D. BY REGISTRAR			39b. REGISTRAR'S SIGNATURE			40. DATE REC'D. BY REGISTRAR			40b. REGISTRAR'S SIGNATURE			41. DATE REC'D. BY REGISTRAR			41b. REGISTRAR'S SIGNATURE			42. DATE REC'D. BY REGISTRAR			42b. REGISTRAR'S SIGNATURE			43. DATE REC'D. BY REGISTRAR																																																																																																																										

06418 AUG 31 87

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Handwritten signature or initials.]

AUG 31 87

063275 AUG 20 1987

FOR
REGISTRATIONSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH23931
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Marvin			MIDDLE KORNBLUH			LAST KORNBLUH			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8-15 1987			2b. HOUR 11:29 PM				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 7-15 - 27		6. AGE (IN YEARS) (LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-15-87			7d. HOUR 11:29 PM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SYSTEMS ANALYST				12b. KIND OF BUSINESS OR INDUSTRY U.S.GOV'T			
13a. STATE MD				13b. COUNTY MONTGOMERY				13c. CITY OR TOWN BETHESDA				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 6421 HOLLINS DR			
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN KORNBLUH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE ROTHCHILD															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 121-20-1316				17. INFORMANT WIFE ADDRESS BETHESDA, 20817 ISADORA KORNBLUH: 6421 HOLLINS DR.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDISTINCT																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2300 P.M. 0815 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED ON DANCE FLOOR											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) DANCE HALL				21f. LOCATION STREET CITY OR TOWN COUNTY STATE GLENECHO PARK BETHESDA MONT. MD											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE Francis C. Mayle				TITLE (SPECIFY) M.D. DET				MEDICAL EXAMINER				DATE SIGNED 8/16/87							
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle				ADDRESS 8200 Wisconsin Ave Bethesda MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 8/18/87				23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN				23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH: FAIRFAX: VIRGINIA							
24. FUNERAL DIRECTOR'S NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR 20852				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REMAINS. PAGES 1, 2, AND 3 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (S))

06352 AUG 50 81



THE O. J. DIA 31

064242 AUG 31 1987

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 3 2

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Catherine</u> MIDDLE <u>T.</u> LAST <u>Korson</u> CATHERINE T. KORSON		2a. DATE OF DEATH MONTH <u>8</u> DAY <u>23</u> YEAR <u>87</u>		2b. HOUR <u>9:14</u> AM	
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH <u>10</u> DAY <u>20</u> YEAR <u>27</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>59</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Canada</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Bethesda</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>Spiro</u> MIDDLE <u>--</u> LAST <u>Tzaferis</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Irene</u> MIDDLE <u>--</u> LAST <u>Averinos</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579-42-2286</u>		17. INFORMANT ADDRESS <u>Koula Mechelis, 312 Penwood Rd, Sil. Spr., MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA OF LEFT LUNG</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ADULT ONSET DIABETES MELLITUS</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> (AT WORK) (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>FEB 20</u> , 19 <u>87</u> , to <u>AUG 23</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>AUG 20</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
23. SIGNATURE <u>Amesh. Braumann</u>				23c. DATE SIGNED <u>8/24/87</u>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas A Brown, MD</u>				23d. ADDRESS <u>4480 PHYSICIANS LANE #251 ROCKVILLE MD 20850</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8/26/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>	
23d. LOCATION CITY OR TOWN <u>Silver Spring, MD</u>		23e. COUNTY <u>Montgomery</u>		23f. STATE <u>MD</u>	
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u>		24b. ADDRESS <u>5130 Wisconsin Ave, NW, Washington, D.C. 20016</u>		25. REGISTRY <u>AUG 28 1987</u>	

MEDICAL CERTIFICATION

Excluded by ME

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician indicate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 applies and injury, or other traumatic event, the medical examiner will be notified at once.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM

TO : DIRECTOR, FBI (100-441111)

FROM : SAC, NEW YORK (100-111111)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

35. [Illegible]

36. [Illegible]

37. [Illegible]

38. [Illegible]

39. [Illegible]

40. [Illegible]

41. [Illegible]

42. [Illegible]

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45. [Illegible]

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48. [Illegible]

49. [Illegible]

50. [Illegible]

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55. [Illegible]

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95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or any other significant event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JACOB KOWALSKY			2a. DATE OF DEATH MONTH DAY YEAR August 12, 1987		2b. HOUR 2:45a.M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1913		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Designer (Retired)		12b. KIND OF BUSINESS OR INDUSTRY Ladies Handbag				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST Harry Kowalsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Borenstein		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 093-07-4458		17. INFORMANT ADDRESS Potomac, Md. 20852 Dr. Ronald Koval; Son; 1 Stoney Creek Way;		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from 2/86 , 19 86 , to 8/16 , 19 87 , that (we) last saw the deceased alive on 8/10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.						
22b. SIGNATURE J. H. Weiner DEGREE				22c. DATE SIGNED Aug. 12, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAY H. WEINER, M.D.				22e. ADDRESS 4701 Randolph Road, #G-3; Rockville, Md. 20852		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/87		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens; Olney; Montgomery; Md.		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR AUG 14 1987				
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike; Rockville, Md. 20852		25b. REGISTRAR'S SIGNATURE F. J. [Signature]				

BP

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11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 3 4

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Kathryn

Millar

Kraybill

20. DATE OF DEATH MONTH DAY YEAR
August 18, 198720. HOUR A
6:00 M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
June 6, 1895

6. AGE (IN YEARS LAST BIRTHDAY)

92 YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

15025 Eardley Court

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Educator

12b. KIND OF BUSINESS OR INDUSTRY

Library

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

15025 Eardley Court / 20906

14. FATHER'S NAME
FIRST MIDDLE LAST

George

William

Miller

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

Margaret

Ellen

Shorb

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

234-60-8617

17. INFORMANT

Margaret K. Schafer, Same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Adenocarcinoma Colon

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 1/2 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

Coronary Stenosis, Hypertension

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/12, 19 82, to 8/18, 19 87, that (I) (we) last saw the deceased alive on 8/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL ☐ STAFF
DIRECTOR ☐ PHYSICIAN ☐

22c. DATE SIGNED

8/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Daniel J. Goldberg

22e. ADDRESS

370 Rossmore Blvd - Silver Spring, MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

8-18-87

23c. NAME OF CEMETERY OR CREMATORY

Metropolitan Crematory

23d. LOCATION
CITY OR TOWN

Alexandria, Virginia

24. FUNERAL DIRECTOR
NAME

Richard Rapp, Inc.

P. O. Box 43352, Washington, DC 20010

25a. DATE RECEIVED BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

AUG 20 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner should be notified and a post-mortem examination should be performed.

003320 AND SI 63



065239 SEP 14 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23935

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Natalie R. Lamb			2a. DATE OF DEATH MONTH DAY YEAR August 29, 1987		2b. HOUR 9:32 am		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6800 Connecticut Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer P. Rust		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha L. Jordan				13e. STREET ADDRESS / ZIP CODE 6800 Connecticut Ave. 20815	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-62-6186		17. INFORMANT ADDRESS David B. Lamb (son) same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, Chronic bronchitis.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7.7. 1987 to 8.29. 1987 , that (I) had lost saw the deceased alive on 8.25. 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) and did not view the body after death.							
22b. SIGNATURE Saulius Naujokaitis MD				DEGREE MD		22c. DATE SIGNED 8.31.87.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAULIUS NAUJOKAITIS MD				22e. ADDRESS 3301 NEW MEXICO AVE. WASHINGTON, D.C. 20016.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY MD Silver Spring, Montg.	
24. FUNERAL DIRECTOR NAME ADDRESS George R. Snowden Rockville, MD 20850				25a. DATE REC'D. BY REGISTRAR SEP 04 1987		25b. REGISTRAR'S SIGNATURE ma Davidson-Jordan	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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064870 SEP 8 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23936
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRY M. LANGHIRT		2a. DATE OF DEATH MONTH DAY YEAR Aug 29 1987		2b. HOUR 4 ²⁰ PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 11 1909	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center, Gaithersburg		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 403 RUSSELL AVE. APT. 205 20877		12b. KIND OF BUSINESS OR INDUSTRY INS. CO.	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH LANGHIRT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOHANNA SCHEPER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASST. TREASURER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-05-8416		17. INFORMANT ADDRESS MARY LANGHIRT (WIFE) SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable no signs DUE TO, OR AS A CONSEQUENCE OF (b) neurogenic bladder DUE TO, OR AS A CONSEQUENCE OF (c) chronic brain syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: atrial fibrillation					
19a. DATE OF OPERATION 8/29		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1985 , to 8/29 , 19 87 , that (I) (we) last saw the deceased alive on 8/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John R. Melnick		DEGREE MD		22c. DATE SIGNED 8/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Melnick		22e. ADDRESS 911 Russell Ave. Gaithersburg, Md 20879		22f. PHYSICIAN'S NAME (TYPE OR PRINT) John Melnick	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/2/87		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.		24. FUNERAL DIRECTOR NAME ADDRESS SCHMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR SEP 4 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

064870 SEP-88

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064348 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 3 7

1. DECEASED NAME (TYPE OR PRINT) A NN - C. Las Kowski		2a. DATE OF DEATH MONTH DAY YEAR 8-25-87		2b. HOUR 1155 am	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 04 29 21		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago, IL		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		10. CITY OR TOWN OF DEATH Beltsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital, Bethesda, MD	
12a. USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS / ZIP CODE 4706 Grace Street / 60125	
13b. COUNTY Cook		13c. CITY OR TOWN Schiller Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William - Freschke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine - Freschke		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A	
16b. SOCIAL SECURITY NO. 337-148309		17. INFORMANT Charles Lasowski		ADDRESS Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) possible acute pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aspiration pneumonia, seizure disorder secondary to probable cerebral hypoxia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the undersigned) attended the deceased from 8/25 1987, to 8/25 1987, that (I) (we) last saw the deceased alive on 8/25 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lycemina, M.D.		DEGREE		22c. DATE SIGNED 8/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilhemina G Comins MD		22e. ADDRESS 4912 ARDEN ST. Rockville MD 20853			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 29 1987		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE River Grove, Illinois		24. FUNERAL DIRECTOR NAME ADDRESS Ives-Pearson F. H. Arlington, Va.			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE AUG 31 1987 John Davidson			

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Aug 31 1935

064103 AUG 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 3 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret H. Latta			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1987		2b. HOUR 745 AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 11, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Harvey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Heydrick		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-44-4493	
17a. INFORMANT NAME ADDRESS Barbara J. Wyckoff		17b. INFORMANT NAME ADDRESS Keyes Ferry Acres		17c. INFORMANT NAME ADDRESS Box 620, Harpers Ferry, W.V. 25425		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer, primary undetermined DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with multiple metastases DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Dietary Malnutrition							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 8/23/87 , 19 1987 , to 8/23/87 , 19 1987 , that (we) last saw the deceased alive on 8/23/87 , 19 1987 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) verdict (did not) view the body after death.							
22b. SIGNATURE Austin Pearre Jr.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Austin Pearre, Jr., M.D.		22e. ADDRESS 300 West 9th Street Frederick, Md. 21701					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE August 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Montgomery Crematorium, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 755 Wisconsin Ave. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE John S. ...	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

64334 SEP-1 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 9 3 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace M Laudeman		2a. DATE OF DEATH MONTH DAY YEAR August 27, 1987		2b. HOUR 12:55 P.M.
3. SEX Female.	4. RACE White.	5. DATE OF BIRTH MONTH DAY YEAR May 29, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91. YRS. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.
10. CITY OR TOWN OF DEATH Silver Spring.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Ho.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker.	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland.		13b. CITY OR TOWN Montg.	13c. CITY OR TOWN Silver Spring.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Irby.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Mount.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-40-9817		17. INFORMANT ADDRESS Portola, California. Elizabeth Manwaring. 140 Fawn Ln.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Aug 8 1987 to Aug 8 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE 		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Henderson		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Cremation.	23b. DATE Aug. 29, 1987	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE/WASHINGTON CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.G. MO	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home		25. DATE REC'D. BY REGISTRAR AUG 31 1987		26. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1, 2 and 3) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

64334 SEP-1 64

August 27, 1964

Mr. [illegible]

6802 [illegible] St.

San Francisco

California

Dear Mr. [illegible]:

[illegible]

[illegible]

AUG 31 1964

Film 631, Items 7a, 8, 12a, 12b, 14, 15,

OR
STATE per Aff. 9-16-87 rja
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 4 0

1. DECEASED NAME (TYPE OR PRINT) John Everett Laws			2a. DATE OF DEATH MONTH DAY YEAR July 31, 1987			2b. HOUR 6:45 A M				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cab Driver		12b. KIND OF BUSINESS OR INDUSTRY Private Hotel		
13a. STATE D.C.			13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5516 First St., N.E. 20011	
14. FATHER'S NAME FIRST MIDDLE LAST Wilbert Peters John Laws				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Haston Robinetta Smith						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-26-9736		17. INFORMANT ADDRESS Mrs. Florence G. Laws, wife, same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated prostatic cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years 24 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) this hospital attended the deceased from June 24, 19 69, to July 31, 19 87, that X (we) last saw the deceased alive on July 31, 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>					DEGREE		22c. DATE SIGNED 8/1/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. Thompson					22e. ADDRESS National Institutes of Health, CC 9000 Rockville Pike, Bethesda, Md. 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4 Aug. 87		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME ADDRESS Frazier's Funeral Home 389 Rhode Island Ave. Wash, D.C.					25a. DATE REC'D. BY REGISTRAR Aug 20 1987					
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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064487 SEP 2 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23941

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NGOK HONG LEE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 25, 1987		2b. HOUR 1:40 PM
3. SEX MALE	4. RACE Yellow	5. DATE OF BIRTH MONTH DAY YEAR November 23, 1922	6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center NIH Bethesda, Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chef- Hilton	12b. KIND OF BUSINESS OR INDUSTRY Capitol	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Silver Spring					
14. FATHER'S NAME FIRST MIDDLE LAST UNK Lee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 577-48-3503		17. INFORMANT ADDRESS Mrs. Ida Lee, wife same 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatorenal syndrome secondary to Hepatoma DUE TO, OR AS A CONSEQUENCE OF (c) Hepatoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hepatitis B Surface Antigen Positive					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1987, to August 25, 1987, that (X) (we) last saw the deceased alive on August 25, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE Gabriel P. Haas		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAAS, GABRIEL		22e. ADDRESS National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/87	23c. NAME OF CEMETERY OR CREMATORY Wash. National		23d. LOCATION Suitland PG Md.
24. FUNERAL DIRECTOR'S NAME Hines/Rinaldi		11800 New Hamp Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR SEP 1 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randolph

BP.

084487 285-581

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C. 20250

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 1 4 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEXIE L Leigh			2a. DATE OF DEATH MONTH DAY YEAR 08 30 87			2b. HOUR 09 15 A				
3. SEX FEMALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 09 23 07		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HAT CHECKER		12b. KIND OF BUSINESS OR INDUSTRY MAYFLOWER HOTEL		
13a. STATE MARYLAND					13b. COUNTY PR GEORGES		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN CROCKETT MOORE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BARBARA HELTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-2837		17. INFORMANT NIECE ADDRESS SANDRA D. MCWHERTER, 11910 CORONADA PL KENSINGTON, MD 20895					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>death pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF <i>with respiratory failure</i> (b) <i>asphyxiation</i> DUE TO, OR AS A CONSEQUENCE OF <i>acute myocardial inf.</i> (c) <i>acute myocardial inf.</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Post Coronary (breast, blood).</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8/16/87</i> , 19____, to <i>8/30/87</i> , 19____, that (I) (we) last saw the deceased alive on <i>8/30/87</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Michael A. Rodriguez</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/29/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. RODRIGUEZ						22e. ADDRESS <i>831 University Blvd. S. Spring</i> <i>MD 20901</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT 2, 1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGES MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.						25a. DATE REC'D. BY REGISTRAR SEP 02 1987				
500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901										

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be filled in by the funeral director and page 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

004004 SEP-3-81

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SEP 03 1981

064243 AUG 31

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23943

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert C. Leonard		2a. DATE OF DEATH MONTH DAY YEAR 8/25/87		2b. HOUR 10³² AM	
3. SEX M Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 06 09		6. AGE (IN YEARS LAST BIRTHDAY) 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Chevy Chase	
14. FATHER'S NAME FIRST MIDDLE LAST Otis Theodore Leonard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Craven		16. STREET ADDRESS / ZIP CODE 3500 Windsor Place 20815	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		17b. SOCIAL SECURITY NO. 1932-1957 245-60-5103		17c. INFORMANT Catherine H. Leonard Same as item #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Blunt Force Head and Neck Trauma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) the hospital attended the deceased from Aug 24 19 87 to Aug 25 19 87 , that (I) was last saw the deceased alive on Aug 24 19 87 , and that in my own opinion death occurred on the date and hour and from the causes stated above, (I) do did not view the body after death.					
22b. SIGNATURE Wm. Luckett		DEGREE MD		22c. DATE SIGNED 8.25.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. Luckett, M.D.		22e. ADDRESS 5000 Reno Rd. Wash. DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/1/87		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Arl., VA		23e. DATE REC'D. BY REGISTRAR AUG 28 1987		23f. REGISTRAR'S SIGNATURE J. L. Rindner-Randall	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the completed pages 1 and 2 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

064243 AUG 31 87

Robert J. Brown

Male

U.S.A.

Continued Off. U.S. Navy

Mont. Chevy Chase

Male

1975-1977 245-60-2117 Catherine H. Brown Same as item 13

Unack'd, n.o.

2/1/87

Also in Ave. 10, Wash., DC 20506
General Services Administration, Inc.

064587 SEP 2 1987

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (PRINT) JACK LEVINE			2a. DATE OF DEATH MONTH AUGUST DAY 23 YEAR 1987			2b. HOUR 6:37P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH APRIL DAY 24 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS XX DAYS XX	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2303 WESTVIEW DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY ACCOUNTANT	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST ABRAHAM MIDDLE LEVINE LAST LEVINE				15. MOTHER'S MAIDEN NAME FIRST HELEN MIDDLE PERLBERG LAST PERLBERG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 088-12-1250		17. INFORMANT DORA LEVINE, 2303 WESTVIEW DRIVE, SILVER SPRING, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GLIOBLASTOMA									
19a. DATE OF OPERATION MA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> MA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kathryn S. Kirwin				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHRYN S. KIRWIN MD				22e. ADDRESS 10400 Connecticut Ave Kensington Md					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8/25/1987		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN ADELPHI COUNTY PRINCE GEORGES STATE MARYLAND			
24. DONOR: STEIN HEBREW MEMORIAL FUNERAL HOME NAME ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR AUG 31 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Rodgers			

MEDICAL CERTIFICATION

004287 SEP-58

44-38861-109615

5
064570 SEP-28STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23945
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bertie E. Elizabeth Lewis		2a. DATE OF DEATH MONTH DAY YEAR 8/27/87		2b. HOUR 12 N M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9/15/1906		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store
13a. STATE WV		13b. COUNTY Berkeley	13c. CITY OR TOWN Martinsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hinton Nicewarner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Janet Dunn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-07-1988	17. INFORMANT ADDRESS Nelson E. Robinson 2101 Boyd Orchard Rd. Martinsburg, WV 25401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK A) WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 7-1 1987 to 8-27 1987, that (I) was lost saw the deceased alive on 8-27 1987, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did (did not) view the body after death.				
22b. SIGNATURE John Tauber		DEGREE MD		22c. DATE SIGNED 8-27-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS Bethesda Md. 8218 WISCONSIN AVE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/29/87	23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Charles Town Jefferson WV
24. FUNERAL DIRECTOR Brown Funeral Home		327 W. King St POBox 821 Martinsburg, WV 25401		25a. DATE REC'D. BY REGISTRAR SEP 01 1987
		25b. REGISTRAR'S SIGNATURE Davidson-Pendall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit requires carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

084230 SEP-5 81

100-100000-100000

100-100000-100000

064643 SEP-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23946

1. DECEASED NAME (TYPE OR PRINT) <i>Clarence W Lidie</i>			2a. DATE OF DEATH MONTH <i>August</i> DAY <i>23</i> YEAR <i>1987</i>			2b. HOUR <i>5:32 P</i>	
3. SEX <i>MALE</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH <i>8</i> DAY <i>25</i> YEAR <i>04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <i>WASHINGTON, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>GAS FITTER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>WASHINGTON GAS & LIGHT CO.</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>KENSINGTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <i>CLARENCE</i> MIDDLE <i>(NMI)</i> LAST <i>LIDIE</i>		15. MOTHER'S MAIDEN NAME FIRST <i>ISABELLA</i> MIDDLE <i>(NMI)</i> LAST <i></i>		13e. STREET ADDRESS / ZIP CODE <i>10920 CONNECTICUT AVE./20895</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>577-07-7748</i>		17. INFORMANT ADDRESS <i>4612 WOODFIELD RD. BETHESDA, MD. 20814</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>perforated duodenal ulcer</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>COPD: cardiomyopathy</i>							
19a. DATE OF OPERATION <i>8/21/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>perforated duodenal ulcer</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/20</i> , 19 <i>87</i> , to <i>8/23</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/21</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kathryn S. Kirwin</i> MD				DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/24/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KATHRYN S. KIRWIN MD</i>				22e. ADDRESS <i>10400 Connecticut Ave, Kensington MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>8/26/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BLUE RIDGE CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>THURMONT FREDERICK MD.</i>	
24. FUNERAL DIRECTOR <i>Ralph E. Dettl</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 02 1987</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1 week

new standard view

8/21/87
 COPD; conditionally
 perforated standard view
 X

062133 AUG

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

23941

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE KNOWN OF DEATH		2d. DATE KNOWN OF DEATH	
LONNIE						LIPSCOMB		MONTH DAY YEAR		MONTH DAY YEAR		MONTH DAY YEAR		MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. DATE PRONOUNCED DEAD	
Male		Black		09 10 18		68		MONTHS		DAYS		8 3 1987		8 3 1987	
11. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED		12. BALTIMORE CITY OR COUNTY OF DEATH		13. BALTIMORE CITY OR COUNTY OF DEATH	
S.C.		U.S.A.										Montgomery		MD	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		16. USUAL OCCUPATION (TYPE OF WORK)		17. KIND OF BUSINESS OR INDUSTRY									
Bethesda		Suburban Hospital		Laborer											
18a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18b. COUNTY		18c. CITY OR TOWN		18d. INSIDE CITY LIMITS?		18e. STREET ADDRESS							
MD		MONTGOMERY		KENSINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10755 HARTSBURG ST							
19. FATHER'S NAME		MIDDLE		LAST		20. MOTHER'S MAIDEN NAME		MIDDLE		LAST					
Unknown						Sally Lipscomb									
21a. WAS DECEASED EVER IN U.S. ARMED FORCES?		21b. SOCIAL SECURITY NO.		21c. INFORMANT		21d. ADDRESS									
No		250-34-7341		Regina Littlejohn (daughter)		same as #13									
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
				MYOCARDIAL INFARCTION											
				INTERDISCLEROTIC CARDIOVASCULAR DISEASE											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
06/08/87		08 03 1987		COLLAPSED WALKING ACROSS PARKING LOT											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY		STATE			
		PARKING LOT		10900 ROCKVILLE PK		BETHESDA		MONT		MD					
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion							
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED									
Francis C. Mayle		Sgt				8/2/87									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Francis C. Mayle		200 Wiscasset Ave Bethesda MD		Removal		8-8-87		Foster Funeral Home		Gaffney		S. C.			
24. FUNERAL DIRECTOR		NAME		25a. DATE RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
George R. Snowden		246 N. Washington Rockville, MD 20850		AUG 06 1987		J. Snowden									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PHA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25AMBP
DHMH - 17
(VR A15 ME (5))

064038

AUG 20 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23748

FOR
1 - STATE
REGISTRAR

DECLASED NAME

FIRST PAUL

MIDDLE MERRILL

LAST LISH

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

8/18/87

1715 M

3. SEX

MALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

MONTH

DAY

YEAR

2 2 21

6. AGE (IN YEARS LAST BIRTHDAY)

66

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

McCammon, Idaho

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery,

MD

10. CITY OR TOWN OF DEATH

Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Shady Grove Adventist

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. COUNTY

Frederick

13d. CITY OR TOWN

Frederick

13e. INSIDE CITY LIMITS?

YES ☐ NO ☒

13f. STREET ADDRESS / ZIP CODE

7986 Quay Ct. / 21701

14. FATHER'S NAME

FIRST

Marion

MIDDLE

Merrill

LAST

Lish

15. MOTHER'S MAIDEN NAME

FIRST

Viola

MIDDLE

Davis

LAST

Davis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

(IF YES, GIVE WAR OR DATES)

WWII

16b. SOCIAL SECURITY NO.

519-10-1252

17. INFORMANT

Mrs. Grete Lish

ADDRESS 7986 Quay Ct.

Frederick, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Sepsis

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

1 week

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CHRONIC Liver Disease Rule Out Alcoholic CA.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 8/18/87, to 8/18/87, that (I) (we) last saw the deceased alive on 8/18/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

8/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Stephen Hellman

22e. ADDRESS

6246 Mountrose Rd

Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/21/87

23c. NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Frederick Frederick Md.

24. FUNERAL DIRECTOR

Robert E. Dailey & Son F.H.

ADDRESS 1201 N. Market

Frederick, Md.

25a. DATE REC'D. BY REGISTRAR

AUG 26 1987

25b. REGISTRAR'S SIGNATURE

[Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial-transit permit. Then please remove carbon papers, sign and date, and forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a Medical Examiner must be notified at once.

BP

DHMH - 16 60M 7/84

(VRA 15, 4)

004038 WNC 30 93



COLLOID-FIBER

WNC 30 93

063264 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23949

1. DECEASED NAME (TYPE OR PRINT) BARRY WARNER LITZ			2a. DATE OF DEATH MONTH DAY YEAR AUGUST-13, 1987			2b. HOUR 1930 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 11 1958		6. AGE (IN YEARS LAST BIRTHDAY) 29		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SHADY-GROVE-ADVENTIST-HOSPITAL				12a. USUAL OCCUPATION Vice President		12b. KIND OF BUSINESS OR INDUSTRY Music Center	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 19701 Bodmer Ave. 20837	
14. FATHER'S NAME FIRST MIDDLE LAST Victor W. Litz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Drucilla Fitch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-78-3507			17. INFORMANT (NAME AND ADDRESS) Victor W. Litz (Father) 20837 19701 Bodmer Ave. Poolesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumocystis pneumonia DUE TO, OR AS A CONSEQUENCE OF Acquired immune deficiency syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Herpes simplex									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION 7/26									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/26 , 19 87 , to 8/13 , 19 87 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/13 , 19 87 , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Robert Prussobius						DEGREE M.D.		22c. DATE SIGNED 8/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BIRSCHBAUGH, H. Robert						22e. ADDRESS 12901 Montgomery Village Ave. Gaith.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/14/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR Lyson Wheeler Funeral Home, Inc.									
1331 Rockville Pike Rockville, Md. 20852						DATE RECEIVED BY REGISTRAR AUG 19 1987		REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit is required for the removal of the body from the place of death to the place of burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062669 AUG

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23950
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helene Louise			2a. DATE OF DEATH MONTH DAY YEAR 4 AUG 87			2b. HOUR 5:49 PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 10 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH SNYDER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8811 Colesville Road 20910		
14. FATHER'S NAME FIRST MIDDLE LAST Frederick W Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Lynch			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. 214 36 3395	
17. INFORMANT Same as 13E Carol Halderman (Daughter)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK FROM MULTIFORME DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 2 MONTHS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION 6/10/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/1 , 19 87 , to 8/4 , 19 87 , that (I) (we) lost saw the deceased alive on 8/4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LARRY EINBLINDER				22e. ADDRESS 2200 WISCONSIN AVE SEIN, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/7/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.					
24. FUNERAL DIRECTOR Hines/Rinaldi				11800 New Hamp Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR AUG 12 1987		25b. REGISTRAR'S SIGNATURE Julia Denson-Rudolph			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This allows removal of the body from the place of death. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



062446 AUG 12 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove embalmers papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>THELMA</u> MIDDLE <u>MAE</u> LAST <u>LUCAS</u>					2a. DATE OF DEATH MONTH <u>8</u> DAY <u>1</u> YEAR <u>87</u>			2b. HOUR <u>5:50</u> PM	
3. SEX <u>F</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>8</u> DAY <u>31</u> YEAR <u>35</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>51</u> YRS		7. IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> HOURS <u></u> MIN <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Charleroi, PA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD			
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington Adventist Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>County Govt</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>731 Easley Street 20910</u>	
14. FATHER'S NAME FIRST <u>Clarence</u> MIDDLE <u></u> LAST <u>Helterbran</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Beulah</u> MIDDLE <u></u> LAST <u>Williams</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>165-27 6788</u>		17. INFORMANT ADDRESS <u>Patricia Hunt 731 Easley St. Silver Spring</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>myocardial infarction</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u>712</u> CITY OR TOWN <u>PA</u> COUNTY <u>PA</u> STATE <u>PA</u>		22a. I certify that (1) (this hospital) attended the deceased from <u>7/2</u> 19 <u>87</u> , to <u>7/1</u> 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>7/1</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.			
22b. SIGNATURE <u>Dr. Lewis Dennis MD</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/1/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Lewis Dennis MD</u>				22e. ADDRESS <u>6201 Greenbelt Rd. Suite U17 Greenbelt, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8-5-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monongahela Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Monongahela</u> COUNTY <u>Washington</u> STATE <u>PA</u>			
24. FUNERAL DIRECTOR NAME <u>FRYE FH</u> ADDRESS <u>MONONGAHELA CITY PA</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 5 1987</u>		25b. REGISTRAR'S SIGNATURE <u>John Gordon-Randall</u>			

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "STANDARD" and "UNIT" are faintly visible.]

064665 SEP

FOR
REGISTRATIONSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH23752
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
Naomi		T.		Lucius				8		27		19		87		1:57 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE		MONTH		DAY		YEAR	
F	W	11 15 95		91 YRS.		MONTHS		DAYS		8		27		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Missouri		USA		WIDOWED		DIVORCED		Montgomery Co.								MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Spring		Holy Cross Hospital		DOCTOR		PRIVATE											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20910									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
MARTIN		WILLIAM		LUCIUS		IDA		ELVIN		KELIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		EXECUTOR		ADDRESS		321 NORWOOD RD							
NO		217-18-2471		BARBARA L. PATTON/		SILVER SPRING, MD		20904									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
888		IMMEDIATE CAUSE (a)		Pulmonary Embolus													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		Fracture Rt. Hip												11 days	
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
2-18-87		Fracture Rt. Hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
FELL		9:15 AM		FELL AT NURSING HOME													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)		21f. LOCATION													
NOT WHILE AT WORK		N/A		Ozlawen Deshpande Mont Md													
22a. I certify that I took charge of the remains described above, held an autopsy		Inspection		Inquiry		and in my opinion											
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
JOHN ROGERS		M.D.		SEMINARY ROAD SILVER SPRING, MD		Aug 27 1987											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
CREMATION		AUG 28, 1987		METROPOLITAN CREMATORY		ALEXANDRIA		VIRGINIA									
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
FRANCIS J. COLLINS, JR.		500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901				SEP 02 1987		John Collins, Jr.									

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

BP
DHMH - 17
(VR A15 ME (5))
15M7/77

001802 200100

U.S. AIR FORCE
OFFICE OF THE SECRETARY
WASHINGTON, D.C.

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SEP 03 1967
[Handwritten signature or initials]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23953

1- FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)FIRST
JOHNMIDDLE
RANDOLPHLAST
LUTHER2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR A
AUGUST 28, 1987 3:20 M3 SEX
MALE4 RACE
WHITE5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 27, 19246 AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YEAR IF UNDER 24 HRS.
62 YRS. MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penn.7b. CITIZEN OF WHAT COUNTRY?
USA8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD10 CITY OR TOWN OF DEATH
ROCKVILLE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1602 Auburn Ave.12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY
Hosp. Consultant Consulting

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Md.13b. COUNTY
Mont.13c. CITY OR TOWN
Rockville13d. INSIDE CITY LIMITS?
YES ☐ NO ☐13e. STREET ADDRESS / ZIP CODE
1602 Auburn Ave. 2085014. FATHER'S NAME
FIRST MIDDLE LAST
JOHN THOMAS LUTHER15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EDNA - ALLEN16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WWII16b. SOCIAL SECURITY NO.
195-14-551217. INFORMANT ADDRESS
Evelyn F. Luther Same as # 1318. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Bladder Cancer

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

9 mos.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on July 10, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE

JPSmith

DEGREE

ATTENDING ☒ MEDICAL ☐ STAFF
PHYSICIAN DIRECTOR PHYSICIAN

22c. DATE SIGNED

8-28-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. Fred Smith

22e. ADDRESS

5401 Western Ave. Chevy Chase, Md. 20815

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

AUG. 31, 1987

23c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven

23d. LOCATION
CITY OR TOWN COUNTY STATE

Silver Spring Mont. Md.

24. FUNERAL DIRECTOR

NAME

ADDRESS

MURIEL H. BARBER LAYTONSVILLE, MD. 20879

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

SEP 02 1987

J. H. Barber

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

084050 219-381

MADE IN U.S.A. 100% COTTON

2003 100% COTTON

062573 AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 4 5 4

1. DECEASED NAME (TYPE OR PRINT) Robert Eugene Lutz			2a. DATE OF DEATH MONTH DAY YEAR 8 6 87			2b. HOUR 6:42a M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 13, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 902 Winhall Way		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		15. KIND OF BUSINESS OR INDUSTRY Auto Repair			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring			17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			18. STREET ADDRESS / ZIP CODE 902 Winhall Way / 20902			
19. FATHER'S NAME FIRST MIDDLE LAST James Morris Lutz			20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Toppin						
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		22. SOCIAL SECURITY NO. 577-03-6526		23. INFORMANT Frances Cummings Silver Spring, Maryland					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic adenocarcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			33. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)			34. LOCATION STREET CITY OR TOWN COUNTY STATE			
35. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>86</u> , to <u>8/16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>June 29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
36. SIGNATURE <u>Mark Rosen</u>			37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			38. DATE SIGNED 8/6/87			
39. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen			40. ADDRESS Silver Spring, MD						
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			42. DATE August 8, 1987		43. NAME OF CEMETERY OR CREMATORY Mt. Jackson Cemetery		44. LOCATION CITY OR TOWN COUNTY STATE Mt. Jackson Virginia		
45. FUNERAL DIRECTOR NAME ADDRESS Dellinger Funeral Home, Inc South Main Street, Mt. Jackson, Virginia 22842									
46. DATE REC'D. BY REGISTRAR AUG 11 1987									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

085213 WPC 1301



APR 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23955

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KYLE CHARLES MACKETT			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 8, 1987		2b. HOUR 2:05AM
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 19, 1983		6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BETHESDA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1540 INGRAM TERRACE 20906	
14. FATHER'S NAME FIRST MIDDLE LAST Dr. Charles Mackett III		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Michele			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 000-00-0000		17. INFORMANT ADDRESS DR. CHARLES MACKETT III, FATHER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) BURKITT'S LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 8 MONTHS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 17, 19 87, to AUGUST 8, 19 87, that (X) (we) lost saw the deceased alive on AUGUST 8, 19 87, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Peter C. Adamson		DEGREE MD		22c. DATE SIGNED 8/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER C. ADAMSON		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 8-10-87	23c. NAME OF CEMETERY OR CREMATORY Amigone Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Towanda NY	
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home, Inc 17 9th Street, N.W. Washington, D. C. 20011		25a. DATE REC'D BY REGISTRAR AUG 18 1987		25b. REGISTRAR'S SIGNATURE John D. ...	

BP

003300 AUG 51 01

SECTION 101



4/1/51

CM

RECEIVED 10 AUG 51

1000 6 1000

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 5 6

063976 AUG 28 87

1 - STATE
REGISTRAR

2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
8/20/87		8 20 87		1120 P M	
3. SEX		4. RACE		5. DATE OF BIRTH	
MALE		BLACK		MONTH DAY YEAR 11 25 01	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Pennsylvania		United States		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		Holy Cross Hospital		Dean	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. CITY OR TOWN	
Architecture		D.C.		Washington	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4721 Colorado Avenue N.W. 20011	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Henry B. Mackey		Anna T. Wills		YES, NO OR UNKNOWN (IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
577-52-1256		Howard H. Mackey, Jr.		Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		19. MEDICAL CERTIFICATION		20. DATE OF OPERATION	
IMMEDIATE CAUSE (a) <u>CARDIO-Pulmonary Insufficiency with Shock</u>		DUE TO, OR AS A CONSEQUENCE OF		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
(b) <u>Bilateral Pneumonia with Septic Shock</u>		DUE TO, OR AS A CONSEQUENCE OF		20a. AUTOPSY?	
(c) <u>Renal Failure</u>		DUE TO, OR AS A CONSEQUENCE OF		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
		YES <input type="checkbox"/> NO <input type="checkbox"/>		21b. TIME OF INJURY	
				HOUR A.M. MONTH DAY YEAR	
				P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	
		WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> 19 <u>87</u> to <u>8/20</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>8/20</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
		ANANTHA RAO		8/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. MEDICAL CERTIFICATION	
ANANTHA RAO		831 UNIVERSITY BLVD. S.S. MD 20903		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		8/26/87		Eden Cemetery	
23d. LOCATION		23e. NAME OF CEMETERY OR CREMATORY		23f. LOCATION	
Philadelphia, Pennsylvania		Eden Cemetery		City or Town County State	
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D BY REGISTRAR	
McGuire Funeral Service, 7400 Georgia Ave. N.W.		Washington, DC		AUG 26 1987	
24d. NAME		24e. ADDRESS		24f. SIGNATURE	
McGuire Funeral Service, 7400 Georgia Ave. N.W.		Washington, DC		Julia Anderson-Rudolph	

0 2 3 7 0 102 23 91

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23957

063025 AUG 18 87

1. DECEASED NAME (TYPE OR PRINT) WILLIAM GREGORY MACKEY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 12, 1987			2b. HOUR 8:19p M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 13, 1968		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE FLORIDA		13b. COUNTY Collier	13c. CITY OR TOWN IMMOKALEE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1117 MONROE AVE, 33934	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM Maurice MACKEY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carley Jean Mackey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS WILLIAM M. MACKEY (FATHER) SAME AS ABOVE			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 HOUR

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) ACUTE PULMONARY EMBOLISM

4 HOURS

DUE TO, OR AS A CONSEQUENCE OF

(c) MYELODYSPLASTIC SYNDROME

2 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he/she) attended the deceased from NOVEMBER 17, 19 86, to AUGUST 12, 19 87, that (we) last saw the deceased alive on AUGUST 12, 19 87, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (do not) view the body after death.							
22b. SIGNATURE W.D. Hoffmann, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Hoffmann, MD				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, CC, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE August 15, 1987	23c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Immokalee Collier Florida
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.		25a. DATE REC'D. BY REGISTRAR AUG 17 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Robertson
7557 Wisconsin Avenue, Bethesda, Maryland 20814			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial home permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

083052 WNE 1881

AUG 17 1881

062874 AUG 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please register this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 3 9 5 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helene E. Maginnis			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1987		2b. HOUR 10:45am		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 5, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4701 Willard Avenue #934		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pianist		12b. KIND OF BUSINESS OR INDUSTRY Instructor	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Finnamom		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Federline		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-48-3761	
17. INFORMANT ADDRESS Harry Maginnis/husband same as 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Malignant Mesothelioma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>87</u> , to <u>Aug 8</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Aug 6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles P. Davall</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8-10-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles P. Davall MD</u>		22e. ADDRESS <u>3301 New Mexico Ave NW, Wash DC</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Mont MD</u>	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		ADDRESS 500 University Blvd. W Silver Spring, MD 20901		25a. DATE REC'D. BY REGISTRAR <u>Aug 11 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

065874 AUG 17 84

062967 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 5 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert E. Maher M.D.			2a. DATE OF DEATH MONTH DAY YEAR Aug. 8 1987		2b. HOUR 10:15AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR April 24 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Doctor		12b. KIND OF BUSINESS OR INDUSTRY Private Prat.
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10401 Grosvenor Pl. (20852)
14. FATHER'S NAME FIRST MIDDLE LAST Robert -- Maher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor -- Monahan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --	17. INFORMANT Wife		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 3 , 19 87 , to Aug. 8 , 19 87 , that (I) (we) last saw the deceased alive on 8/8/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frauke Westphal M.D.		DEGREE		22c. DATE SIGNED August 8, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.		22e. ADDRESS 809 Viers Mill Roadm, Rockville, MD 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-10-87	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.
24. FUNERAL DIRECTOR DeVol Funeral Home, 2222 Wisconsin Avenue, Washington, D.C. 20007			25a. DATE REC'D. BY REGISTRAR AUG 17 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, pages 1 and 2, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062087 AUG 19 07

10:15AM

AUG 19 1907

M.I.

7.

U.S.A.

New York

Medical School, Trinity Park.

John Greenway Pl. (1907)

Montgomery, Rockville

Robert

Robert

Elleanor

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No

W.B. No 100

Harry Lawrence Lee Warner

Wife

Married
June 19 19



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AUG 19 1907

Washington D.C.

Wt. Olive Company

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LINE

AUG 17 1907

062370 AUG 11 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a necropsy performed.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23960

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lester L. Malcolm			2a. DATE OF DEATH MONTH DAY YEAR 08 06 87			2b. HOUR 14:20pm			
3. SEX MALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 02 12 18		6. AGE (IN YEARS LAST BIRTHDAY) 69Y		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		8b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GENERAL CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY BUILDING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13212 NEW HAMPSHIRE AVE 2090P	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY H. MALCOLM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA MARGARET ARMSTRONG		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 218-09-2100		17. INFORMANT ADDRESS HAZEL C. MALCOLM, 13212 NEW HAMPSHIRE AVE S.S. MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulm arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) massive CVA 7 day DUE TO, OR AS A CONSEQUENCE OF (c) cor artery disease 7 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: asthma chronic pneumonia Pituitary insuff									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Jan 19 65 to Aug 6 19 87 , that (2) (we) last saw the deceased alive on Aug 5 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. H. Sandstrom MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug 7 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. H. Sandstrom MD				22e. ADDRESS 7741 Carrell Ave Takoma Park, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 9. 1987		23c. NAME OF CEMETERY OR CREMATORY King Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi MD			
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, 2500 14th St NW, DC				25. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall			

BP

085370 AUG 11 81

[Faint, mostly illegible handwritten text on lined paper, possibly a ledger or notebook page. Some words like "DATE", "TIME", and "LOCATION" are faintly visible.]

062173 AUG 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 9 6 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice T. Marston			2a. DATE OF DEATH MONTH DAY YEAR August 2, 1987			2b. HOUR 10:40 AM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 6, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3381 South Leisure World Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Microbiologist		12b. KIND OF BUSINESS OR INDUSTRY Microbiology					
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3381 S. Leisure World Blvd/20906	
14. FATHER'S NAME FIRST MIDDLE LAST Howard G. Marston						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice T. McKee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None				16b. SOCIAL SECURITY NO. 025-26-9552		17. INFORMANT ADDRESS Margery Clark 4523 Everett St. Kensington, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>diabetes mellitus ; chronic dementia</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>87</u> , to <u>Aug 2</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>July 15</u> 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Mark S. Rosen MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Aug/3/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen, M.D.						22e. ADDRESS 3941 Ferrara Dr. Wheaton, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug/3/87		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rodwell</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 9 6 2
REG. NO.

1. FOR
STATE
REGISTRAR

062720 AUG 14 87

1. DECEASED NAME (FOR PRINT) <u>Joaquin V. Martinez</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>8-10-87</u>		2b. HOUR <u>6:55</u> M
3. SEX <u>Male</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>April 1, 1898</u>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <u>89</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Cuba</u>	7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> County, MD	
10. CITY OR TOWN OF DEATH <u>Bethesda</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Lawyer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Private Practice</u>
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Bethesda</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joaquin V. Martinez</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mariana Martinez</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u>		16b. SOCIAL SECURITY NO. <u>577-68-1780</u>		17. INFORMANT ADDRESS <u>Mrs. Mariana M. Prats 8502 Ewing Drive Bethesda, Md. 20817</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hour</u>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<u>hour</u>
(b) <u>Cardiac pulmonary failure</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Small bowel obstruction</u>		<u>2 days</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION <u>8/8/87</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Small bowel obstruction</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> , 19 <u>87</u> , to <u>8/10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Elisa J. Martinez M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>8/10/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ELISA J. MARTINEZ M.D.</u>		22e. ADDRESS <u>8808 Hidden Hill LA. - Potomac</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>August 14, 1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery Silver Spring Maryland</u>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 13 1987</u>	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to examine the body.

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085550 YAG 14 83

065659 SEP 15 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23963

1. DECEASED NAME (TYPE OR PRINT) MARIA. L. MARTINEZ			2a. DATE OF DEATH MONTH 8 DAY 30 YEAR 87			2b. HOUR 0608AM			
3. SEX F Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH October DAY 8 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS YRS. DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) San Salvador		7b. CITIZEN OF WHAT COUNTRY? San Salvador		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7667 Maple Avenue #402 20912	
14. FATHER'S NAME FIRST Ascension MIDDLE Giron LAST Martinez			15. MOTHER'S MAIDEN NAME FIRST Maria MIDDLE L. LAST Martinez						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 152-64-3586		17. INFORMANT Flavia A. Martinez/ daughter same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema, Urinary Tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Coronary Artery disease?								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from 8/29/87 , 19 87 , to 8/30/87 , 19 87 , that (I) (we) last saw the deceased alive on 8/30/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE Tony P. Karmarkat			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TONY P. KARMARKAT, MD			22e. ADDRESS 8201 16th ST SILVER SPRING, MD 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE Sept 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. W Silver Spring, MD 20901			25a. DATE REC'D. BY REGISTRAR 9-2-87			25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

97
35
150
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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Centre for the study of
the human mind
University of Cambridge

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 3 9 6 4

1. FOR
STATE
REGISTRAR

2. DECEASED NAME (TYPE OR PRINT) LINDA RAE MCGRATH			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10 1987			7b. HOUR 9:55 A		
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR APRIL 15 1945		
6. AGE (IN YEARS (LAST BIRTHDAY)) 42 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
11. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		
13a. STATE VIRGINIA			13b. COUNTY FAIRFAX			13c. CITY OR TOWN ALEXANDRIA		
14. FATHER'S NAME FIRST MIDDLE LAST HAROLD HUBERT CARLSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER LOUISE SKONNORD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 541-52-0602			17. INFORMANT ADDRESS MARTIN MCGRATH, 8500 CAMDEN STREET,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALEXANDRIA, VA 22308 METASTATIC CERVICAL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 3, 19 87 , to AUGUST 10, 19 87 , that (I) (we) lost saw the deceased die on AUGUST 10, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated								
22b. SIGNATURE <i>Edward B. Weiser</i>			DEGREE MD			22c. DATE SIGNED 13 AUG 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD B. WEISER, CDR, MC, USN			22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-19-1987			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEM.		
23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, ARL. CO., VA.			24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.			25a. DATE REC'D. BY REGISTRAR AUG 24 1987		
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			25c. REGISTRAR'S SIGNATURE					

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063905 AUG 27 07

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 23405

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
DENNIS		A		McGraw	8		20	87		9 ¹⁰ PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS.		
MALE	Caucasian		MONTH DAY YEAR 5 15 10		77 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				Montgomery MD						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Silver Spring	Holy Cross Hospital		Ass't. Chief Individual Income Tax		IRS						
13a. STATE	13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland	Pr. Geo.		W. Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		1410 East West Highway		20783		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Thomas McGraw		Julia Doolan									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW II		214-07-6942		Mary Devlin McGraw Wife		Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line 18(a), 18(b), and 18(c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Cardiac shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Metastatic bronchogenic carcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTE</u> <u>HOUR</u> <u>YEAR</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <u>8/19/87</u> to <u>8/20/87</u> , that (2) we last saw the deceased alive on <u>8/20/87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (3) we (I) did not view the body after death.		22b. SIGNATURE <u>Samuel Ittner</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/21/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL ITTNER		22e. ADDRESS 10313 Georgia Avenue #307 Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Aug. 25, 1987		Arlington National		Arlington Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Francis J. Collins, Jr. 500 University Blvd., W. Silver Spring, Md. 20901		AUG 26 1987									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

083002 AUG 52 01

083002 AUG 52 01

062071 AUG 8 1987

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23460

REG. NO.

2. DECEASED NAME (TYPE OR PRINT) BOBBY J McPHAIL			2a. DATE OF DEATH MONTH DAY YEAR 8-1-1987			2b. HOUR 3 AM			
3. SEX MALE		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 6-12-30		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Allied Bendix	
13a. STATE Maryland		13b. COUNTY PG		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15408 Bond Mill Rd 20707	
14. FATHER'S NAME FIRST MIDDLE LAST unknown McPhail			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Mae Brand			16. ADDRESS Kay McPhail 15408 Bond Mill Rd Laurel Md 20707			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT Kay McPhail		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: (c) CORONARY HEART DISEASE			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-31-87 to 8-1-87 , that (I) (we) last saw the deceased alive on 8-1-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) M. H. CHAUDHRY				22c. ADDRESS 14201 LAUREL PARK DRIVE #600 LAUREL MD 20707 (953-7420)		22d. DATE SIGNED 8-1-87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/4/87		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont MD			
24. FUNERAL DIRECTOR NAME Beck Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR AUG 06 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Thereafter, remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

065071 AUG-88

AUG 06 1988

064239

AUG 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23967

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Deane Russ Meier			2a. DATE OF DEATH MONTH DAY YEAR August 3, 1987		2b. HOUR 5:00 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE DC	13b. COUNTY N/A	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4201 Mass. Ave. NW 20016	
14. FATHER'S NAME FIRST MIDDLE LAST William Earl Russ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie E. Bell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-62-4294		17. INFORMANT ADDRESS Dennis M. McHugh 200 A Monroe St. Rockville, MD 20850	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Refractory Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from January 31, 1987 to August 3, 1987 , that (I) (we) last saw the deceased alive on July 31, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Christopher Unger MD				22c. DATE SIGNED 8/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger, M.D.				22e. ADDRESS 8218 Wisc. Ave., Bethesda, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/25/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA		23e. DATE REC'D. BY REGISTRAR AUG 28 1987			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25b. REGISTRAR'S SIGNATURE John Andrew Randall	

MEDICAL CERTIFICATION

999999

999999

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must have the certificate prior to the removal of the body from the place of death with the State Dept. of Health and Mental Hygiene prior to transportation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

064238 AUG 31 87

Deane Russ Meier August 3, 1987 2:00 PM

Female Caucasian 100.18, 1902

Ohio U.S.A. x Montgomery County

Rockville Potomac Valley Nursing Home Homewood

Rocky Mt Washington x 4321 Penn. Ave. NW 20016

William 1271 Russ 10000

NO 10000 Dennis M. 10000 200 A Monroe St. Rockville

*

8/3/87

Christopher Weger, M.D. 8218 Wisc. Ave., Bethesda, MD 20814

Washington 8/3/87 Mr. Sanford Dismorey Alexandria, VA

7200 VI Ave. NW, Wash., DC 20016

AUG 28 1987

062162 AUG 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23968

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Leonarda, MIDDLE: Amelia, LAST: Meyer			2a. DATE OF DEATH MONTH: August, DAY: 2, YEAR: 1987		2b. HOUR 10:30 ^A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH: Nov., DAY: 6, YEAR: 1924	6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS: , DAYS: , IF UNDER 24 HRS. HOURS: , MIN: .	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Prince Geo.	13c. CITY OR TOWN Seabrook	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST: Antoni, MIDDLE: , LAST: Bykoski			15. MOTHER'S MAIDEN NAME FIRST: Julianna, MIDDLE: , LAST: Spartzak		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-18-5848	17. INFORMANT Husband Mr. Frederick W. Meyer, Jr. same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: , A.M. MONTH: , DAY: , YEAR: 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET: , CITY OR TOWN: , COUNTY: , STATE:	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 28</u> , 19 <u>81</u> , to <u>August 2</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 2</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>John J. Wright</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN J. WRIGHT M.D.</u>		22e. ADDRESS <u>National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/05/87	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN: Baltimore, COUNTY: , STATE: MD
24. FUNERAL DIRECTOR OR OTHER PERSON IN CHARGE Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781		25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

MEDICAL CERTIFICATION

F

22

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

085105 AUG 10 03

OMIBEL

AUG 11 07

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
JG 11 07

999999
07/84
25M
BP
DHMH - 17
OVR 315 ME

085511 AUG 11 85

63525 AUG 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23970
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE VIRGINIA MILLER			2a. DATE OF DEATH MONTH DAY YEAR July 30 1987		2b. HOUR 0735 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 29, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SNADY GROVE ADVENTIST HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLARK		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	
13a. STATE MARYLAND		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 2719-HAWTHORNE TERR. 20875		14. FATHER'S NAME FIRST MIDDLE LAST ROBERT L. BRANTNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY -- BROWNING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 234-01-7165		17. INFORMANT ADDRESS REV. DR. REICHARD- N.L.H.-ROCKVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) the hospital attended the deceased from Jan 1 , 19 97 , to July 30 , 19 87 , that (1) was last saw the deceased alive on July 27 , 19 87 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did not) view the body after death.							
22b. SIGNATURE Thomas E. Dooley, M.D.				DEGREE		22c. DATE SIGNED July 30, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Dooley, M.D.				22e. ADDRESS 9701 VIERS DRIVE ROCKVILLE, MARYLAND 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 3, 1987		23c. NAME OF CEMETERY OR CREMATORY ROSEDALE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE MARTINSBURG, W.VA.	
24. FUNERAL DIRECTOR NAME ADDRESS HYSONG CO., INC-1300 N ST., NW WASH., DC				25a. DATE REC'D BY REGISTRAR AUG 21 1987		25b. SIGNATURE John E. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove section 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked, item 18 above, any injury, or other traumatic or medical condition must be notified at once.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 34 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND METAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PLESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR AURAL.

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23971	
1- DECEASED NAME (TYPE OR PRINT)												REG. NO.	
1a. DECEASED NAME (TYPE OR PRINT) Earl Dana Miller												2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> MONTH DAY YEAR 8 7 87	
1b. SEX Male												2b. HOUR 12 30 P.M.	
1c. RACE White												2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 7 87	
1d. DATE OF BIRTH MONTH DAY YEAR 10 18 09												2d. HOUR 12 30 P.M.	
1e. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.													
1f. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.													
1g. IF UNDER 24 HRS.													
1h. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia												1i. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
1j. CITIZEN OF WHAT COUNTRY? United States													
1k. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
1l. CITY OR TOWN OF DEATH Bethesda												1m. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Certified Accountant	
1n. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital												1o. KIND OF BUSINESS OR INDUSTRY Self-employed	
1p. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
1q. STATE Maryland												1r. STREET ADDRESS 5109 Fairglen Lane / 20815	
1s. COUNTY Montgomery													
1t. CITY OR TOWN Chevy Chase													
1u. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
1v. FATHER'S NAME FIRST MIDDLE LAST David Miller												1w. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruby (Unavailable)	
1x. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No												1y. SOCIAL SECURITY NO. 578-03-7655	
1z. INFORMANT Marion M. Miller, Same as 13													
2a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cystic Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH												21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK												21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John Tauber</u> M.D. <u>Spitz</u> TITLE (SPECIFY) <u>Bethesda Md.</u> DATE SIGNED <u>8-7-87</u>													
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tauber</u> ADDRESS <u>3218 Wisconsin Ave</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation												23b. DATE 8-10-87	
23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory												23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME P. O. Box 43352, Washington, DC 20010												25a. DATE REC'D. BY REGISTRAR AUG 12 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>													

005854 MAR 13 81

RECEIVED ACTION 3/13/81

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WV

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23972

1. DECEASED NAME FIRST MIDDLE LAST Inez Milligan			2a. DATE OF DEATH MONTH DAY YEAR 8 19 87		2b. HOUR 0855 M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 08 13 13		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Berwyn Heights		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Fehrman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Hanft					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 483-26-8373		17. INFORMANT ADDRESS Richard Seelmeyer (nephew) Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypercalcemia DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma origin Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Uncontrolled Diabetes mellitus, Coronary Heart Disease, Hypertensive Heart Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 27 , 19 87 , to August 19 , 19 87 , that (I) (we) last saw the deceased alive on August 19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE CHIN-CHUAN HSU				DEGREE MD		22c. DATE SIGNED 8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHIN-CHUAN HSU				22e. ADDRESS 6419 Baltimore Avenue Riverdale, MD 20737			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/20/87		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem. Adelphi Prince Geo.		23d. LOCATION CITY OR TOWN COUNTY STATE MD	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, MD 20781				25a. DATE REC'D. BY REGISTRAR AUG 26 1987		25b. REGISTRAR'S SIGNATURE Julian Swenson-Rodarte	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

84018 and 28



Handwritten notes at the bottom of the page, including the date "Aug 28 1937" and other illegible text.

061940 AUG -787

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23973
REG. NO.FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

George

J.

Miner

2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
2b. HOUR
2c. DATE ESTI- MATED
MONTH DAY YEAR
2d. HOUR
08/02/87 1939

3 SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2e. DATE PRONOUNCED DEAD

MONTH DAY YEAR

2f. HOUR

Male

C

01/09/04

83 YRS.

MONTHS

DAYS

HOURS

MIN.

08 02 1987

1939

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED

NEVER MARRIED

9. BALTIMORE CITY OR COUNTY OF DEATH

Pennsylvania

U. S. A.

WIDOWED

DIVORCED

Montgomery County

MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

12a. USUAL OCCUPATION (TYPE OF WORK)

12b. KIND OF BUSINESS

Takoma Park, Md.

Washington Adventist Hospital

U. S. Gov'tmt.

Technician

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

Maryland

Montgomery

Takoma Park

YES ☒ NO ☐

404 Lincoln Avenue

14. FATHER'S NAME

15. MOTHER'S MAIDEN NAME

Henry J. Miner

Clara

Shick

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

16b. SOCIAL SECURITY NO.

17. INFORMANT

8421 11th Ave

NO

178-10-1791

Dolores Miner Sil. Spr, Md. 20903

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which

gave rise to immediate

cause (a) stating the under-

lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Acute Myocardial Dis.

Chronic Obstructive Pul. Dis.

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

Yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

None

None

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

21b. TIME OF INJURY

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

UNDERLYING ☐ ORCONTRIBUTING ☐ CAUSE OF DEATH

P.M.

21d. INJURY OCCURRED

21e. PLACE OF INJURY (AT HOME,

21f. LOCATION

WHILE ☐ NOT WHILE ☐

STREET, FACTORY, FARM, ETC.)

STREET

CITY OR TOWN

COUNTY

STATE

AT WORK ☐ AT WORK ☐

22a. I certify that I took charge of the remains described above, held on

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL

TITLE (SPECIFY)

SIGNATURE

M.D.

MEDICAL EXAMINER

DATE

EXAMINER'S NAME

M.D.

MEDICAL EXAMINER

DATE

(TYPE OR PRINT)

M.D.

MEDICAL EXAMINER

DATE

ADDRESS

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

COUNTY

STATE

(SPECIFY)

Burial

8-6-1987

St. Joseph Cemetery

Warren,

Penna.

24. FUNERAL DIRECTOR

ADDRESS

254 Carroll St, N.

25. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Takoma Fun'l Home

Wash, D.C. 20012

AUG 5

1987

Julia Gordon-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 104.3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR AT5 ME (5))

062154 AUG 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23974
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA B. Mitchell		2a. DATE OF DEATH MONTH DAY YEAR 08-03-87		2b. HOUR 735 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1896	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
17a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac	
14. FATHER'S NAME FIRST MIDDLE LAST William Hauserman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bianca Wasserstraus		17b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Manager	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 352-10-4248		17c. KIND OF BUSINESS OR INDUSTRY Grocery	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERFORATED ABDOMINAL VISCUS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 Hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic Renal failure; chronic congestive heart failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 31, 1987 to August 3, 1987 , that (I) (we) last saw the deceased alive on August 3, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.					
22b. SIGNATURE James E. Wilson, M.D.		DEGREE M.D.		22c. DATE SIGNED 8/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Wilson, Jr. M.D.		22e. ADDRESS 11125 Rockville Pike, Ste. 103, Rockville, Md. 20853			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Highland Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Libertyville Illinois		24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		25a. DATE REC'D. BY REGISTRAR AUG 7 1987	
25b. REGISTRAR'S SIGNATURE Julia Denson-Randall		25c. REGISTRAR'S SIGNATURE Julia Denson-Randall			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23975
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LOIS KATHLEEN MOORE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 10 1987			2b. HOUR 8:30 P M				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 27 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE		
13a. STATE VIRGINIA			13b. COUNTY FAIRFAX		13c. CITY OR TOWN ANNANDALE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7814 KALORAMA ROAD 22003	
14. FATHER'S NAME FIRST MIDDLE LAST CLAYTON EMERSON BRANDT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIOLA ELSIE REINHARDT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 212-05-0336		17. INFORMANT ADDRESS JOHN MOORE, 7814 Kalorama Road, Annandale VA 22003					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CERVICAL CANCER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 7 , 19 87 , to AUGUST 10 , 19 87 , that (I) (we) last saw the deceased alive on AUGUST 10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Drew E Lewis</i>						DEGREE MD		22c. DATE SIGNED 10 Aug 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Drew E Lewis Jr, MC, USMC						22e. ADDRESS NAVAL HOSPITAL BETHESDA, MARYLAND 20814-5011				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/14/87		23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR NAME ADDRESS DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VA 22314						25a. DATE REC'D. BY REGISTRAR AUG 13 1987				
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23976
REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST CARL F. MORGAN		2a. DATE OF DEATH MONTH DAY YEAR Aug. 4, 1987		2b. HOUR 18 30 PM	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH MONTH DAY YEAR 11 8 1893	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COLORADO		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	
10. CITY OR TOWN OF DEATH SANDY SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIENDS NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Electric			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN Wash. DC	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK GEORGE MORGAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLLIE MAE WILLIAM		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 343-01-1735		17. INFORMANT Miss Dee Morgan	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF, (b) <u>CONGESTIVE CARDIOMYOPATHY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>PS.</u> DUE TO, OR AS A CONSEQUENCE OF, (c) <u>ALZHEIMERS DISEASE</u> <u>PS.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>TERM.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>CARCINOMA BLADDER</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>5/26</u> 19 <u>87</u> , to <u>8/4</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>2/28</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Donald R. Lewis MD</u>		DEGREE MD		22c. DATE SIGNED 8-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD		22e. ADDRESS OLNEY MD 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/5/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory	
23d. LOCATION Alexandria, Virginia		23e. STATE Virginia			
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, INC. 5130 WI Ave NW Wash. DC 20016		25a. DATE REC'D BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE Julia Fisher-Rudolph	

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John D. ...

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 REG. NO. 7
1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RITA B. MOSS
2a. DATE OF DEATH
KNOWN ☒ ESTIMATED ☐
MONTH DAY YEAR
8 31 1987
2b. HOUR
M
2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8 31 1987
2d. HOUR
M
6P
9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD3. SEX FEMALE
4. RACE WHITE
5. DATE OF BIRTH
MONTH DAY YEAR
MAY 21 1956
6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Snady Grove Adventist Hosp.
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) PROPERTY MANAGER
12b. KIND OF BUSINESS OR INDUSTRY R.J.M. ENTERPRISESUSUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD
13b. COUNTY MONT.
13c. CITY OR TOWN POOLESVILLE
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS 19514 FISHER AVE.
2083714. FATHER'S NAME
FIRST MIDDLE LAST
WALTER BRZOZOWSKI
15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARIA RIEAL16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 579-766-588
17. INFORMANT ADDRESS
ROBERT A. MOSS, 19514 FISHER AVE POOLESVILLE18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8120 IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY?
YES ☒ NO ☐21a. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY
HOUR MINUTE MONTH DAY YEAR
4 P.M. 8-31-1987
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
Driver of auto/auto collision.21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☒
AT WORK AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road
21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Rt. 28 w. of Berryville Rd., Montgomery, MD22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) Deputy Chief
M.D. MEDICAL EXAMINER DATE SIGNED 9-1-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL
23b. DATE SEPT. 4 1987
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md24. FUNERAL DIRECTOR ME Takoma Funeral Home, 257 Connel St. N.E. ADDRESS
25a. DATE REC'D. BY REGISTRAR SEP 8 - 1987
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23978
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
EDWARD JAMES MULDOON								AUGUST 21, 1987										12:10 am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.									
MALE		WHITE		OCTOBER 9, 1950		36 YRS.		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Alabama		USA				MONTGOMERY COUNTY MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BETHESDA		NIH, THE CLINICAL CENTER		Lt./C		U.S. Navy													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE											
FLORIDA		Escambia		PENSACOLA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6302 LAKE CHARLENE DRIVE 32506											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST		FIRST MIDDLE LAST																	
Edward J. Muldoon Sr.		Mildred - Hudson																	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		1973-1985		256-84-8725		MRS. AUDREY MULDOON (WIFE)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
		Cardiac Arrest				Minutes													
				(b) Pericardial Tamponade		1 hour													
				(c) Acquired Immunodeficiency Syndrome		3 years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION															
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 3, 1985, to AUGUST 21, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 21, 1987, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
HENRY MASUR MD				8/21/87															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
		NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Cremation		8/24/87		Chambers Crematory		Riverdale		P.G.		Md.									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
NAME		ADDRESS																	
W.W.Chambers Co. Inc.		Riverdale Md.		AUG 27 1987		Julia Davidson-Randall													

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W. B. Chambers Co. Inc.

95507-11

signature: [illegible]

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FOR
STATE
REGISTRAR

IMOGENE

W.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23979

1. DECEASED NAME (TYPE OR PRINT) <i>Imogene W Muller</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8-3-87</i>		2b. HOUR <i>1 A</i>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>JULY 16, 1903</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 84	
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wilson Health Care Center Gaithersburg, Md.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN GAITHERSBURG	
14. FATHER'S NAME JAMES C. WOOD		15. MOTHER'S MAIDEN NAME EMMA JACKSON		16. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		17b. SOCIAL SECURITY NO. 220-34-6301		17c. INFORMANT HENRY J. MULLER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alzheimer's Dementia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>ASHD with premature ventricular beats</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <i>March 8, 1984</i> , to <i>Aug 3, 1987</i> , that (we) last saw the deceased alive on <i>July 31, 1987</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James R. Moore Jr.</i>		DEGREE <i>MD.</i>		22c. DATE SIGNED <i>8-3-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James R. Moore Jr.</i>		22e. ADDRESS <i>207 Brookes Ave Gaithersburg Md.</i>			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE AUG. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
24. FUNERAL DIRECTOR MURIEL H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR AUG 06 1987		25b. REGISTRAR'S SIGNATURE <i>James R. Moore Jr.</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

085058 AUG-88

CHIEF IN CHARGE



AUG 09 1988

064892 SEP 8 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRS 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23980
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry Douglas Mumaw		2a. DATE OF DEATH MONTH DAY YEAR 8-26-87		2b. HOUR 0330 AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11-22-1920		6. AGE (IN YEARS LAST BIRTHDAY) 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waiter		12b. KIND OF BUSINESS OR INDUSTRY Restaurants
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lester Mumaw		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Helsley		13e. STREET ADDRESS / ZIP CODE 7620 Franklin Apt., Maple Ave. 20912	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2 226-12-2425		17. INFORMANT ADDRESS 4214 75th Avenue, Landover Hills, Maryland 20784 Mrs. Lena Holzer,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral pneumonia with abscess DUE TO, OR AS A CONSEQUENCE OF (c) Acquired immune deficiency					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1976 to August 1978 , that (I) (we) last saw the deceased alive on 8/25 , 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert J. Gerel				22c. DATE SIGNED 8/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. GEREL MD				22e. ADDRESS 4410 74th Ave Landover Hills MD 20784	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-31-87		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery Cheltenham, P.G., Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. NAME OF CEMETERY OR CREMATORY FRANCIS GASCH'S SONS FUNERAL HOME, P.A.			
23f. ADDRESS 4739 Baltimore Ave., Hyattsville, Maryland		23g. DATE REC'D. BY REGISTRAR SEP 4 1987			
23h. REGISTRAR'S SIGNATURE Lia Darden-Radner		23i. REGISTRAR'S SIGNATURE			

064805 SEP-90

SEP 4 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23981

1. STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECLASED NAME (TYPE OR PRINT) GERTRUDE H MUNDAY		MONTH DAY YEAR 08 22 1987		PM	
3. SEX F	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 09 20 94	6. AGE (IN YEARS) (LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4613 WINDSOR LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock Broker	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA	
14. FATHER'S NAME FIRST MIDDLE LAST Harrison Huffer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 577 09 5543		17. INFORMANT Duncan L. Clarke Lane Bethesda MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 01 22 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND IN BED	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION CITY OR TOWN COUNTY STATE 4613 WINDSOR LANE BETHESDA MONT MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE [Signature]		TITLE (SPECIFY) M.D. DEPT		DATE SIGNED 8/24/87	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle		ADDRESS 8200 Wisconsin Ave Bethesda MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	
23b. DATE Aug. 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Montgomery Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Bethesda Chevy Chase, Inc		25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. BE SURE TO SIGN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSMIT TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

04102 WAC 28 85

20% COTTON FIBRE

064490 SEP-28-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23982
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Overton P. Nederkorn			2a. DATE OF DEATH MONTH DAY YEAR Aug. 26 1987			2b. HOUR 10:10PM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS		7. UNDER 1 YEAR MONTHS DAYS 0 0		8. UNDER 24 HRS HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14120 Amsted Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14120 Amsted Road 20904			
14. FATHER'S NAME FIRST MIDDLE LAST Francis M. Peterson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Winston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS LeMoyne Stouffer-daughter- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Peroration Duodenal Ulcer										2 weeks	
DUE TO, OR AS A CONSEQUENCE OF											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Hypertension, Stroke											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (XXXXX) attended the deceased from January 19 1984 to Aug. 15, 19 87 , that (I) (xx) lost saw the deceased alive on Aug. 15, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) use the body after death.											
22b. SIGNATURE <i>Michael A. Newman</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Aug. 27, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Newman, MD						22e. ADDRESS 916 19th Street, N.W. Wash., DC 20006					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-31-1987		23c. NAME OF CEMETERY OR CREMATORY Montevallo Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Montevallo Alabama			
24. FUNERAL DIRECTOR NAME ADDRESS Hine's/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR SEP 1 1987		25b. REGISTRAR'S SIGNATURE <i>Richard P. ...</i>			

MEDICAL CERTIFICATION

92

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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SON COTTON FIBER

WILKINSON

1981

063306 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23983
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Virginia Lee Nicewarner			2a. DATE OF DEATH MONTH DAY YEAR August 15, 1987		2b. HOUR 7:20p M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR January 28, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistical Typist		12b. KIND OF BUSINESS OR INDUSTRY Retail
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William H. Neild			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Spencer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579 26 1122	17. INFORMANT (Husband) Walter Stuart Nicewarner Same as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 27, 1986, to August 10, 1987, that (I) (we) last saw the deceased alive on August 10, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Heidi Jolson M.D. - covering for John Sala M.D.				22c. DATE SIGNED August 15, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Heidi Jolson M.D.				22e. ADDRESS 9800 Falls Road Potomac, Maryland 20854	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 19, 1987	23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Humphrey Funeral Home/ 300 West Montgomery Avenue Rockville, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 19 1987		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

003300 VME 50 81

AUG 13 1981

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23984
REG. NO.

1. DECEASED NAME (PRINT) HENRY R. NICHOLS			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1987			2b. HOUR 10:15A_M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept 12, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 74 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Rail Road			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 983 Clopper Rd. 20878	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Nichols			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patsy Butler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-16-5223		17. INFORMANT ADDRESS Gaithersburg, Maryland Rosie Rodgers/983 Clopper Rd, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost _____ DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> 19 <u>86</u> , to <u>8/14</u> <u>8/XXX</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Christopher Unger, M.D.</i>						22c. DATE SIGNED 8/17/87			22d. PHYSICIAN'S NAME (TYPE PRINT) Christopher Unger, M.D.	
22e. ADDRESS 8218 Wisconsin Ave. #208 Beth. Md. 20814										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/20/87		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Front Royal Warren Va.			
24. FUNERAL DIRECTOR NAME Maddox Funeral Home			ADDRESS 105 W. Main St. Front Royal, Va		25a. DATE REC'D. BY REGISTRAR 8/24/1987		25b. REGISTRAR'S SIGNATURE <i>Julia Tindem-Rudosa</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

003100 AUG 58 81

LIBRARY

001-4520

063191 AUG 19 87

REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23985
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Nicholson			2a. DATE OF DEATH MONTH DAY YEAR August 15, 1987			2b. HOUR 10:50A _M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 1 1896		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Karacousis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Gatsinos					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (son) William Nicholson		ADDRESS 8621 Bunnell Drive Rockville, Md. 20854				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>7 hours death heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>8/1</u> 19 <u>87</u> to <u>8/15</u> 19 <u>87</u> , that (I) (we) <u>last</u> saw the deceased alive on <u>8/15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Alan Weinstein</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/15/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Alan Weinstein</u>					22e. ADDRESS <u>10313 Georgia Ave Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-18-1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home					11800 N. H. Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR AUG 18 1987		
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B above any injury, or other traumatic event, the medical examiner must be notified at once.

BP

003101 JUA 101030

20% COLL 104 1030

003101 JUA 101030

063972 AUG 28 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH OTHER RECORDS. PAGE 5 SHOULD BE FILED WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT) Alice C. NIEDFELDT		7a. DATE KNOWN OF DEATH ESTI-MATED 8-23-87		7b. HOUR 2:38	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 11 DAY 8 YEAR 1960	6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Trans. Specialist	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Potomac	
14. FATHER'S NAME FIRST James MIDDLE Tilghman LAST Crawford		15. MOTHER'S MAIDEN NAME FIRST Hilda MIDDLE Mary LAST Ericson		12b. KIND OF BUSINESS OR INDUSTRY GAO	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-14-4127		17. INFORMANT ADDRESS Elinor M. Conversano Same as Item 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Coronary arteriosclerosis (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .	
ACTUAL SIGNATURE John Tauber	TITLE (SPECIFY) Deputy MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) John Tauber	DATE SIGNED 8-23-87
ADDRESS Bethesda Md. 8218 WILSONSON Ave.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/26/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR AUG 26 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandey

07-84
25M

BP
DHMH - 17
(VR A15 ME (5))

063072 AUG 28 81

WINDLIFT

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W. A.

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W. A. Specialist (W)

064656 SEP-30-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23981

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Alice B. NILON</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>8-24-87</u>		2b. HOUR <u>9:05 PM</u>
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>6-30-06</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>81</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>A.C.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY COUNTY MD</u>	
10. CITY OR TOWN OF DEATH <u>OLNEY</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>SHARON NURSING HOME</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>	13c. CITY OR TOWN <u>SILVER SPRING</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Jessee G. Ball</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>LAVINIA Kretz</u>		13e. STREET ADDRESS / ZIP CODE <u>3400 GLEN EAGLES DRIVE 20906</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>579-38-5024</u>		17. INFORMANT <u>SON</u> <u>DAVID G. COOK</u> ADDRESS <u>5103 DUDLEY LAND</u> <u>#201 BETHESDA, MD 20814</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c) <u>uterine tumor, suspected</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>September 8-24</u> , 19 <u>86</u> , to <u>August</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on above (I) (we) did not view the body after death.					
22b. SIGNATURE <u>TED E. HOWE, MD</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8-24-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>TED E. HOWE, MD</u>		22e. ADDRESS <u>OLNEY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>AUG 25, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>METROPOLITAN</u>	
23d. LOCATION CITY OR TOWN <u>ALEXANDRIA</u>		COUNTY <u>VA</u>		STATE	
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS, JR.</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 02 1987</u>		25b. REGISTERED BY SIGNATURE <u>[Signature]</u>	
500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

004003 219-085

200. (0110) 1152



18-4302

CHICAGO, ILL. (3110)

CHICAGO, ILL. (3110)
CHICAGO, ILL. (3110)

SEP 03 1981

062567 AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 23388

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Solfred		FIRST Solfred		MIDDLE Irene		LAST Nilson		2a. DATE KNOWN OF DEATH ESTI- MATED Aug 6 1987		MONTH 8		DAY 6		YEAR 1987	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 10 YEAR 45		6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN		7c. DATE PRONOUNCED DEAD Aug 6 1987		MONTH 8		DAY 6 YEAR 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norway				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION, TYPE OF WORK FOR MOST OF WORKING LIFE Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9101 Second Avenue / 20910					
14. FATHER'S NAME FIRST Ingolf				MIDDLE Thorsen		LAST Ragna		15. MOTHER'S MAIDEN NAME FIRST Unavailable				MIDDLE (Unavailable)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unavailable				17. INFORMANT Matt C. Nilson,				ADDRESS 3585 Moultrie Avenue San Diego, CA 92117			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE
SIGNEDEXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M. D.

ADDRESS

1919 Seminary Road
Silver Spring, MD 20910

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

Cremation

8-8-87

Metropolitan Crematory

Alexandria, Virginia

24. FUNERAL DIRECTOR
NAME

Richard Rapp, Inc.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

P. O. Box 43352, Washington, DC 20010

AUG 11 1987

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 4, AND 5. GIVE PAGES 1, 2, AND 3 TO THE
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

085283 VNC 1381

1/61 MICHIGAN COTTON FIBER

1961 1-6-61

064421 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
23989
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE L LAST NOEHEL			2a. DATE OF DEATH MONTH DAY YEAR 8-25-87		2b. HOUR 12:00 PM						
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2-1-22		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
13. CITY OR TOWN OF DEATH SILVER SPRING		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK (RETIRED C. & P. PHONE CO)			16. KIND OF BUSINESS OR INDUSTRY		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONT. 13c. CITY OR TOWN SILVER SPRING		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS / ZIP CODE 10412 JULEP AVENUE 20902		20. FATHER'S NAME FIRST MIDDLE LAST CROCKETT LOWE		21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH COLE			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		23. SOCIAL SECURITY NO. 235-34-7676		24. INFORMANT ADDRESS JAMES E. NOEHEL, 10412 JULEP AVE. S.S. MD		25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial IN Fartch DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
26a. DATE OF OPERATION		26b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
27d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		27e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27f. LOCATION STREET CITY OR TOWN COUNTY STATE							
28. I certify that (I) (this hospital) attended the deceased from 8/19/87 to 8/25/87 that (I) (we) lost saw the deceased alive on 8-25-19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.											
29a. SIGNATURE J B Cul		29b. DEGREE MD		29c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		29d. DATE SIGNED 8/25/87					
30a. PHYSICIAN'S NAME (TYPE OR PRINT) Gilbert B. Cushner		30b. ADDRESS 11161 New Hampshire Ave									
31a. BURIAL, CREMATION, REMOVAL Burial		31b. DATE Aug. 28 1987		31c. NAME OF CEMETERY OR CREMATORY Date of Heaven Cemetery		31d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring MD					
32. FUNERAL DIRECTOR NAME Takeshi Funeral Home J. G. Harty		32b. ADDRESS 254 Church Hill DC		32c. DATE REC'D. BY REGISTRAR 8-26-87		32d. REGISTRAR'S SIGNATURE					

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063946 AUG 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23990

1. DECEASED NAME (TYPE OR PRINT) JORDAN NOVAK			2a. DATE OF DEATH MONTH DAY YEAR August 20, 1987			2b. HOUR 12:24pm				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 8 20		6. AGE (IN YEARS LAST BIRTHDAY) YRS 67		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD				
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11805 Tifton Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY IND. CHEMICAL		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11805 Tifton Drive (20854)	
14. FATHER'S NAME FIRST MIDDLE LAST MITCHELL NOVAK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHYL SILBERSTEIN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)				
16b. SOCIAL SECURITY NO. 579-14-9400			17. INFORMANT DAUGHTER			ADDRESS ROCKVILLE, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MO							
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from APRIL 28, 1987 to AUGUST 20, 1987 , that I (we) last saw the deceased alive on 10 AUG 1987 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Walter Goozh</i>								22c. DATE SIGNED Aug. 20, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER GOOZH, M.D.						22e. ADDRESS 2309 Shorefield Road; Wheaton, Md. 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/23/87		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Fairfax, Va.			
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR AUG 26 1987				
						25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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CONFIDENTIAL

CONFIDENTIAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23991
REG. NO.

1. FOR
STATE
REGISTRAR

063955 AUG 27 87

2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK B. OCHSENREITER			2a. DATE OF DEATH MONTH DAY YEAR 8 25 87		2b. HOUR 355 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 23 19		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSTALLER		
12b. KIND OF BUSINESS OR INDUSTRY SHADES & BLINDS		13a. STATE -		13b. COUNTY -		
13c. CITY OR TOWN WASHINGTON DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 725 24th ST. N.W. 20037		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK B. OCHSENREITER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLORIA RICHTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO 578-18-3157		17. INFORMANT ADDRESS GLORIA O. THOMAS, 6720 CHILLUM MANOR ROAD HYATTS MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8/11 19 87		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 8/11/87 to 8/25/87 , that (we) last saw the deceased alive on 8/24/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death, so state.)				
22b. SIGNATURE Mark H. Eig		DEGREE		22c. DATE SIGNED 8/25/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark H. Eig		22e. ADDRESS 9801 Georgia Ave Silver Spring Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE AUG. 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		24. FUNERAL DIRECTOR NAME ADDRESS Tokara Funeral Home Inc, 254 Carroll NW DC				
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE AUG 26 1987				

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062389 AUG 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 9 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHERINE REILLY O'CONNELL			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 02 1987		2b. HOUR 9:02 A.M.
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 14 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN		12b. KIND OF BUSINESS OR INDUSTRY DEPT OF NAVY
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN REILLY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA GERTRUDE CASEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-42-1360		17. INFORMANT ADDRESS ELIZABETH O. BEYMA, RT 12 PIERPONT SOUTH DRIVE MORGANTOWN, WV 26505	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 2</u> 19 <u>87</u> , to <u>Aug. 2</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Aug. 2</u> 19 <u>1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Drew Lewis</i>				22c. DATE SIGNED AUG 02 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DREW LEWIS, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/87		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	
23d. LOCATION TOWN Arlington, Virginia		24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852			
25a. DATE REC'D. BY REGISTRAR AUG 07 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>	

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ONLINE

TABLE 2. O. 2004

REG. NO.

BP_____

063295 AUG 20 87

FOR
MAYLAND
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANZ O. OHLSON, JR.			2a. DATE OF DEATH MONTH DAY YEAR August 15, 1987		2b. HOUR 7:30a M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL-BETHESDA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President		12b. KIND OF BUSINESS OR INDUSTRY Trade Association
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Prince George's	13c. CITY OR TOWN Adelphi	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Franz O. Ohlson, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Lagar		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 087-05-6463		17. INFORMANT Nancy Ohlson ADDRESS 621 W. 113th St. NY, NY 10025	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC LUNG CARCINOMA TO BRAIN</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>may</u> 19 <u>87</u> to <u>AUGUST 15</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JUNE</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>MARTIN S. ROSENTHAL MD</u>		22c. DATE SIGNED 8-15-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN S. ROSENTHAL MD	
22e. ADDRESS 8300 CORPORATE DR., LANDOVER MD.		22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE August 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		23e. DATE REC'D. BY REGISTRAR 20485			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.		25. REGISTRAR'S SIGNATURE 20485			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove page 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked as item 18, please inform the medical examiner, or other responsible person, of the cause of death.

BP
DHMH - 16-60M 7-84
(VRA 15, 4)

AUG 19 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 28, there was any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23995

REG. NO.

1- FOR
STATE
REGISTRAR

2- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Velma E. O'Neal

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
08 02 87 3:20 P.M.

3 SEX
Female

4 RACE
WHITE

5 DATE OF BIRTH
MONTH DAY YEAR
04 07 05

6 AGE (IN YEARS LAST BIRTHDAY)
82

IF UNDER 1 YEAR
MONTHS DAYS

IF UNDER 24 HRS
HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN)
VIRGINIA

7b CITIZEN OF WHAT COUNTRY?
USA

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10 CITY OR TOWN OF DEATH
Silver Spring

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital

12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
WAITRESS

12b KIND OF BUSINESS OR
RESTAURANT

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b STATE
Md

13b COUNTY

Montgomery

13c CITY OR TOWN

Silver Spring

13d INSIDE CITY LIMITS?
YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE
2711 Norbeck Rd 20906

14 FATHER'S NAME
CHARLIE

MIDDLE O'NEAL
LAST

15 MOTHER'S MAIDEN NAME
GRACE

MIDDLE McINTYRE
LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO

16b SOCIAL SECURITY NO.
227-09-5242

17 INFORMANT
ADDRESS
DOROTHY O'NEAL EDWARDS SAME AS #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

renal & pulmonary failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Bleeding duodenal ulcer

DUE TO, OR AS A CONSEQUENCE OF

(c) Bleeding duodenal ulcer

38 d

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION
2-1-87

19b CONDITION FOR WHICH OPERATION WAS PERFORMED
Bleeding duodenal ulcer

20a AUTOPSY?
YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.)

21f LOCATION
STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (the hospital) attended the deceased from 2-29, 1987, to 8-2, 1987, that (I) (we) last saw the deceased alive on 8-2, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c DATE SIGNED

8-3-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

IRA N BRECHER, MD

22e ADDRESS

2101 NW PK Dr Silver Spring MD 20902

23a BURIAL, CREMATION, REMOVAL
CREMATION

23b DATE
AUG. 3, 1987

23c NAME OF CEMETERY OR CREMATORY
BALT. WASH. CREMATORY

23d LOCATION
CITY OR TOWN COUNTY STATE
LAUREL P. GEORGE MD.

24 FUNERAL DIRECTOR

MURTEL H. BARBER LAYTONSVILLE, MD. 20879

25a DATE REC'D. BY REGISTRAR
AUG 5 1987

25b REGISTRAR'S SIGNATURE
Julia Davidson-Randall

1961-12-20

Lester D. [unclear]

[unclear] to [unclear]

[unclear]

[unclear] [unclear] [unclear] [unclear] [unclear]

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

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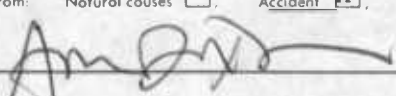

[unclear] [unclear] [unclear] [unclear] [unclear] [unclear]

065427 SEP 14 1987

STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

23996

1 DECEASED NAME (TYPE OR PRINT) Marjorie Ellen Neilly			FIRST MIDDLE LAST PARKS			2a DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 31 19 87				2b HOUR M									
3 SEX female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR May 31 1908		6 AGE (IN YEARS) LAST BIRTHDAY 79 YRS.		IF UNDER 1 YR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b CITIZEN OF WHAT COUNTRY? United States				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD							
10 CITY OR TOWN OF DEATH Rockville				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b KIND OF BUSINESS OR INDUSTRY Dress Shop							
13a STATE Maryland												13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e STREET ADDRESS 508 Woodston Road/20850	
14 FATHER'S NAME FIRST MIDDLE LAST Robert L. Neilly						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Munroe													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 218 38 8865				17 INFORMANT Bethesda, Md. 20817 Sibyl Parks Kitts, 5419 Lincoln St.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 885 IMMEDIATE CAUSE (a) Thoracic trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Chronic obstructive pulmonary disease																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR MONTH DAY YEAR 1:45 P.M. 8-31- 1987				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject tripped over dog.											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) porch				21f LOCATION STREET CITY OR TOWN COUNTY STATE 508 Woodston Rd. Rockville, Montgomery, MD											
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 9-1-87											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201															
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE Sept 10 1987		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland									
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Av. Rockville, Md. 29850						25a DATE REC'D. BY REGISTRAR SEP 10 1987				25b REGISTRAR'S SIGNATURE 									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 3 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25M

BP

DHMH - 17
(VR A15 ME (5))

062135 SEP 14 87

[Handwritten signature]

SEP 14 1987

063564 AUG 24 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23991
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEO PASTERNAK			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1987		2b. HOUR 8:40 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 24, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Tallor	12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Nestula Pasternak			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-5335		17. INFORMANT ADDRESS Barbara S. Rosen 13812 Bonsal Lane, 20906 Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Waldenstrom's Macroglobulinemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Aug</u> 19 <u>87</u> , to <u>17 Aug</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>Aug 16</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u> MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>17 Aug 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Leibowitz, MD</u>		22e. ADDRESS <u>11120 New Hampshire Ave SE, Md 20904</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8/18/1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>District of Columbia Lodge</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.			25a. DATE REC'D. BY REGISTRAR <u>Aug 21 1987</u>		
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been reviewed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It must be filed with the State Dept. of Health and Mental Hygiene prior to removal, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

WIND

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23998

FOR
1. STATE
REGISTRAR

REG. NO.

062297 AUG 1

1. DECEASED NAME (PRINT) Lois Gertrude Patton		2a. DATE OF DEATH MONTH DAY YEAR AUG 1 87 1203 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Apr. 1, 1906	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE DC	13b. COUNTY N/A	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Duffey	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lois Gertrude (Unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO	16b. SOCIAL SECURITY NO. 578-26-1851	17. INFORMANT ADDRESS Robert A. Patton 2859 Hill Rd. Vienna, VA 22108	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ischemic cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) diffuse atherosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ischemic bowel			
19a. DATE OF OPERATION 7/30/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gastroesophageal colon and intestine	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 29, 1987 to Aug 1, 1987 , that (I) (we) last saw the deceased alive on July 31, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Barbara Blacklock, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/1/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Blacklock, M.D.		22e. ADDRESS 6111 Executive Blvd, Rockville, Md. 20852	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/6/87	23c. NAME OF CEMETERY OR CREMATORY National Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, VA
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR AUG 10 1987	25b. REGISTRAR'S SIGNATURE Julia Benson-Budget

062297 AUG 11 07

Patton Gertrude Lola

Female White Tr. 1, 1906 81

Virginia U.S.A.

Hospital

Housewife Home

DC VA Washington

x

2505 MacArthur Blvd. NW

Trout

Daily

Lola

Gertrude

(Unknown)

578-26-1871 Robert A. Patton 2855 Hill Rd. Vienna, VA

NO

8/6/87 National Mem. Park Ellis Grant, VA

Joseph Gaylor's Sons, Inc.
2130 W. Ave. NW Wash., DC 20006

062829

AUG 17 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23999

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Robert Perry			2a. DATE OF DEATH MONTH DAY YEAR Aug. 8, 1987		2b. HOUR 1:35 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 30, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5509 Alta Vista Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto	
13a. STATE Virginia		13b. COUNTY Shenandoah		13c. CITY OR TOWN Edinburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 1 22824	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Perry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Martin					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII				16b. SOCIAL SECURITY NO. 577-14-5760		17. INFORMANT ADDRESS Nina Miller Perry-wife- Rt. 1, Box 223 Edinburg, Va.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Disseminated Lymphoma**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION April 1978		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED L. Kidney invasion		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 1987 to Aug 8 1987 that (I) (we) lost saw the deceased alive on Aug 8 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and did not) view the body after death.							
22b. SIGNATURE Robert T. Thibadeau				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU				22e. ADDRESS ROCKVILLE, MD. 20852			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-11-87		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran Church Cemetery, Jerome, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Dellinger Funeral Home, Inc.				ADDRESS 157 N. Main St Woodstock, Va		25a. DATE REC'D. BY REGISTRAR AUG 14 1987	
				25b. REGISTRAR'S SIGNATURE John F. ...			

4

20702

AGARD

509

6367-1 AUG 25 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24000

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME FIRST MIDDLE LAST Walter Hiram Phillips		August 18, 1987		3:15 AM	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 15 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10002 Markham Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY I.R.S
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Willimas Phillips		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMY Ledyard		13e. STREET ADDRESS / ZIP CODE 10002 Markham Street 20901	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 1		16b. SOCIAL SECURITY NO. 578-01-3491		17. INFORMANT Christine V. Phillips-Wife same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 28, 1984, to AUGUST 18, 1987, that (I) (we) last saw the deceased alive on JULY 1, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE Robert J. Sher		DEGREE MD		22c. DATE SIGNED 8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Sher, M.D.		22e. ADDRESS 10,301 Georgia Avenue Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 20, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montgomery Md.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987	
500 University Blvd. West Silver Spring, Md. 20906		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pudenz			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

03671 YNG 52 81

64655 SEP -3 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
FRANCES		H		PODLESNY				08		29		19		87		20:55	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Fe	C	08 09 24		63 YRS.		MONTHS		DAYS		08		29		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
PENNSYLVANIA		USA		WIDOWED		DIVORCED		MONTGOMERY		MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BETHESDA		SUBURBAN HOSPITAL		HOUSEWIFE													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		MONTGOMERY		SILVER SPRING		YES		2907 BARKER ST		20910							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT									
PETER		MARY		NO		205-18-7700		JOSEPH A. FODLESNY/HUSBAND		SAME AS 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		TRAUMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ACUTE							
884/9				DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES		NO											
21a. EXTERNAL CAUSE		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED													
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		19:55 P.M. 08 29 1987		FELL FROM FIRST FLOOR LANDING													
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION													
WHILE AT WORK		HOME		14504 Drumm Ave Kensington MONTGOMERY MD													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
FRANCIS C MAYLO		MD. SEPT		08/30/87													
EXAMINER'S NAME		ADDRESS															
FRANCIS C MAYLO		200 Wisconsin Ave Bethesda MD															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
BURIAL		SEPT 1, 1987		GATE OF HEAVEN CEM		SILVER SPRING MONT MARYLAND											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS, JR.		SEP 02 1987		John Darden													
500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

100-932-20042

W. A. L. H. A. S. E.



RIGHT MOTION

063900 AUG 26 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 4 0 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul Efraim Poritzky			2a. DATE OF DEATH MONTH DAY YEAR August 22, 1987		2b. HOUR 11:40 ^A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 19, 1959		6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner ----Computer Products		12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13e. STREET ADDRESS / ZIP CODE 5912 Chatsworth Ln. 20814		
14. FATHER'S NAME FIRST MIDDLE LAST Siegbert Poritzky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Selma Cohn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Mr. Siegbert Poritzky, father same			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fungal sepsis</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse histiocytic lymphoma</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION Aug. 9, 1987	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Open Lung Biopsy	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ☒ (this hospital) attended the deceased from December 27, 1985 to August 22, 1987, that ☒ (we) lost the deceased above, ☒ (we) (did) (not) view the body after death, and that in ☒ (my) (our) opinion death occurred on the date and hour and from the causes stated.

22b. SIGNATURE A.G.D. HOFFMAN	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Aug 23/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan G.D. Hoffman		22e. ADDRESS National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892	

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial	23b. DATE Aug. 24, 1987	23c. NAME OF CEMETERY OR CREMATORY King David Mem. Park	23d. LOCATION Falls Church, Virginia STATE
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24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Va. ADDRESS 22046	25a. DATE REC'D. BY REGISTRAR AUG 25 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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AUG 22 1960

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24003

REG. NO.

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST JOHN ADAM PROUDFOOT			2a. DATE OF DEATH MONTH DAY YEAR 8/5/87		2b. HOUR 2341^P
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73	7. UNDER 1 YEAR MONTHS DAYS YRS.
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.	8b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard		12b. KIND OF BUSINESS OR INDUSTRY Protective Agn.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland	13c. CITY OR TOWN Prince Geo. Landover Hills	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7507 Buchanan Street, 20784		
14. FATHER'S NAME FIRST MIDDLE LAST William Methuen Proudfoot		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verna Rockwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-2	17. INFORMANT ADDRESS Fred O. Proudfoot, Same as Line #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF SEPTIC SHOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PNEUMONIA (c) OLD STROKE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OLD STROKE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET 8151 19th St	CITY OR TOWN 815	COUNTY 815	STATE 815
22a. I certify that (I) (this hospital) attended the deceased from 8/5/87 to 8/5/87 , that (I) (we) last saw the deceased alive on 8/5/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE PHYSICIAN		22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. SUDHAKAR, M.D.		22e. ADDRESS 2626 WEL HAMPSHIRE AVE #22 CANDACE PARK, MD 20703			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 08-07-87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia		23d. LOCATION CITY OR TOWN STATE	
24. FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland					
25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial transit permit. Please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 is to be filed with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 states any injury or other traumatic event, a medical examiner must be notified to examine the body.

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AUG 1 1982

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all completed pages. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
FRANCIS		E.		PURKS				AUGUST 22, 1987								11:32PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
MALE		CAUCASIAN		NOV 22 1923		63		YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
WASHINGTON, DC		USA				MONTGOMERY COUNTY										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										C&P TELEPHONE	
OLNEY		MONTGOMERY GENERAL HOSPITAL				OFFICE TECH											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14004 BAUER DRIVE								20853	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JOSEPH		KATHLYN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
YES		1943-1946		578-22-0945		EDNA M. PURKS/WIFE		SAME AS 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic malignant melanoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>87</u> , to <u>8/22</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE <u>John G. Lodmell MD</u>		DEGREE		22c. DATE SIGNED <u>8/23/87</u>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN G. LODMELL, MD</u>		22e. ADDRESS <u>2901 Olney Rd. Olney Md 20832</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		AUG25,1987		GATE OF HEAVEN		SILVER SPRING MONT MARYLAND											
24. FUNERAL DIRECTOR NAME		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901		AUG 26 1987		<u>[Signature]</u>													

063860 AUG 25 81

AUG 26 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and deliver them to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24005
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Donald Joseph Quattrocchi			2a. DATE OF DEATH MONTH DAY YEAR August 24 87		2b. HOUR 1942 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 18, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed		12b. KIND OF BUSINESS OR INDUSTRY Auto body	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11121 Smokey Quartz Lane 20854
14. FATHER'S NAME FIRST MIDDLE LAST Erasamo Quattrocchi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cathryn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579 46 9896		17. INFORMANT Wife Ada P. Quattrocchi Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a HYPERTENSION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> 19 <u>87</u> , to <u>August</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/18/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>GARY M. ROGGIN, MD</u>				22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY M. ROGGIN MD				22e. ADDRESS 10215 FERNWOOD RD BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 27, 1987	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Home Bethesda Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD				25a. DATE REC'D. BY REGISTRAR AUG 27 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP



062153 AUG 10 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maria Teresa Quintero			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 08 02 1987		2b. HOUR 1912
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Mar 19, 1953	6. AGE (IN YEARS) (LAST BIRTHDAY) 34 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD Aug 2, 1987
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchandising	
12b. KIND OF BUSINESS OR INDUSTRY Clothier		13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10664 Muirfield Dr./20854	
14. FATHER'S NAME FIRST MIDDLE LAST Henry R. Quintero		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Wilson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 220-60-0909		17. INFORMANT Henry R. Quintero, Father, see #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Alpha Coma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Drug Overdose</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u> <u>8 days</u> <u>8 days</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM P.M. 0724 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND ON FLOOR AT HOME	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10664 Muirfield Dr Potomac Mont. MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Dyt		DATE SIGNED 8/4/87 20814	
EXAMINER'S NAME (TYPE OR PRINT) Francis J. Mayle, M.D.		ADDRESS 8200 Wisconsin Av., Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION CITY OR TOWN Rockville		COUNTY Maryland		STATE	
24. FUNERAL DIRECTOR Rockville, Inc. 300 W. Montgomery Av., Rockville, Md. 20850		25a. BY RECEIVED BY 25b. SIGNATURE 25c. SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

085123 AUG 10 81



[Faint, illegible handwriting across the middle section of the page, possibly a signature or address.]

[Faint, illegible handwriting at the bottom of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back of this form, it should be detached for use as the burial-transit permit. Then please return it to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial (cremation or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062568 AUG 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24007
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JULIA RABINOWITZ			2a. DATE OF DEATH MONTH DAY YEAR August 9, 1987		2b. HOUR 4:12 P_M	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 4, 1904		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS MONTHS DAYS		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill N.H.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST William Lewis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ira Parvey		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 077 22 6386		17. INFORMANT ADDRESS William Rabin (son) same address as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that XX (the hospital) attended the deceased from JUNE 19 87 to 9 AUG 19 87 , that (1) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (5) (we) did not view the body after death.				
22b. SIGNATURE IRA N. TUBLIN MD		DEGREE MD		22c. DATE SIGNED 9 August 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA N. TUBLIN		22e. ADDRESS 830 Cameron St. Silver Spring				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Aug. 12, 1987		23c. NAME OF CEMETERY OR CREMATORY Cypress Hills Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, New York		24. FUNERAL DIRECTOR Ives-Pearson Funeral Homes NAME ADDRESS Falls Church, Va. 22046				
25a. DATE REC'D. BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S NAME J. P. [Signature]				

BP

21

061808

AUG 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24008

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles F. Bader			2a. DATE OF DEATH MONTH DAY YEAR 8-2-87			2b. HOUR 0135 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 06 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Acct. Office		12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1619 Parham Road 20903	
14. FATHER'S NAME FIRST MIDDLE LAST John Radar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Lohmann					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT ADDRESS Lois S. Riley-dau-1619 Parham Rd. S.S. Md. 20903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHO PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-16, 1987, to 8-2, 1987, that (I) last saw the deceased alive on 8-1, 1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.									
22b. SIGNATURE John Tauber				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-2-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber				22e. ADDRESS Md. 5218 Wisconsin Ave Bethesda A					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-5-1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				1800 N.H. Ave., ADDRESS Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR AUG 04 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

061809 AUG-284

062671 AUG 13 87

FOR
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24009

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
CHRISTOPHER RADOS						8-5-87			19			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Male	White	3 1 68	19			8-5-87			19			2:20a		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Indiana			USA			WIDOWED			DIVORCED			Montgomery County MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			Piney Meeting House Lane nr. Boswell Lane						Student					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Md.			Mont			Potomac			YES			8500 Buckhannon Drive 20854		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
George Rados			Jacqueline Tomey			N/A			316 66 6114			Rev. George Rados (Father) Same as 13E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			1:10AM 8-5-87			passenger in an auto/fixed object impact								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION								
			roadside			Piney Meeting House Lane nr./Rockville, Md. Boswell Lane								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED								
Margarita A. Korell			Assistant			8-6-87								
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS											
Margarita A. Korell, M.D.			111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. STATE		
Burial			8/7/87			Gate of Heaven			S.S.			Mont. Md.		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.						AUG 12 1987			Julia Benson-Randolph					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENICIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM 1000.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

08581 MAR 13 85



08581 MAR 13 85

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24010

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MIRIAM R. RANSOM			MONTH DAY YEAR 8-20-87			HOURS MIN. 8:30 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH		
MONTH DAY YEAR 2-9-1900			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
7a. BIRTHPLACE Baltimore, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Foundation			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 50 Bryants Nursery Rd. 20904					
14. FATHER'S NAME FIRST MIDDLE LAST John Richards			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora A. Kircker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A			17. INFORMANT ADDRESS Margaret North-daughter-(same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left CVA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cortical Atrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>Several Years</u> to <u>20 Aug 1987</u> , that (I) (we) saw the deceased alive on <u>18 Aug 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Marion Chung MD</u>						DEGREE <u>MD</u>		22c. DATE SIGNED 8-20-1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Marion Chung, MD</u>						22e. ADDRESS <u>Leisure World Medical Center - Silver Spring, Md 20906</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-24-1987			23c. NAME OF CEMETERY OR CREMATORY Restland Memorial Pk.		
23d. LOCATION CITY OR TOWN COUNTY STATE East Hanover Morris N.J.			23e. DATE REC'D. BY REGISTRAR AUG 25 1987			23f. REGISTRAR'S SIGNATURE <u>Julia Dandrea-Randall</u>		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR AUG 25 1987		

MEDICAL CERTIFICATION

063887

AUG 26 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

003871 AUG 29 81



AUG 2 5 1981
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063388 AUG 21 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 4 0 1 1

1. DECEASED NAME (TYPE OR PRINT)		FIRST Jon		MIDDLE Philip		LAST RAY		2a. DATE KNOWN OF DEATH		MONTH 8		DAY 13		YEAR 87		2b. HOUR 1030 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 11 35		6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 8 13 87		7d. HOUR 1030 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer				12b. KIND OF BUSINESS OR INDUSTRY Tobacco					
13a. STATE Texas				13b. COUNTY Bexar		13c. CITY OR TOWN San Antonio		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12544 Judson Road/78233							
14. FATHER'S NAME FIRST MIDDLE LAST Burt Firmin Ray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Flippo													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 454-50-0516		17. INFORMANT Brenda R. Ray, same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Adeno Carcinoma of The Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER Bethesda Md.				DATE SIGNED 8-13-87					
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Transit				23b. DATE Aug. 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Mission Burial Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE San Antonio, Texas							
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814				25a. DATE REC'D. BY REGISTRAR AUG 19 1987				25b. REGISTRAR'S SIGNATURE Julia Tidwell-Randall									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00 22 258 AUG 31 61

064671 SEP-30-87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24012
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vermell Veronica Reaves		2a. DATE OF DEATH MONTH DAY YEAR August 30 1987		2b. HOUR A M 10:00
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR January 17 1939		6 AGE (IN YEARS LAST BIRTHDAY) 48 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY Government
13a. STATE D.C.	13b. COUNTY	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4950 Benning Rd. 20019

14. FATHER'S NAME FIRST MIDDLE LAST Alfred T. Barnes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Carter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-52-8777	
17. INFORMANT Sgt. John Reaves, husband		ADDRESS 4950 Benning Rd SE #202	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic breast cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) Superior Vena Cava Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes years days
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that ☒ (this hospital) attended the deceased from August 15, 1986, to August 30, 1987, that ☒ (we) last saw the deceased alive on August 30, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) did not view the body after death.

22b. SIGNATURE Edward Chu mo	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD CHU MO		22e. ADDRESS National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 9/4/87	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland
24. FUNERAL DIRECTOR NAME ADDRESS ALEXANDER S. POPE-2617 Pa Ave SE Wash., D.C.		25a. DATE REC'D. BY REGISTRAR SEP 2 - 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and place them in the container with the body. Page 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

004051 SEP-301

SEP 3 - 1981

63248 AUG 20 87

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24013
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BRENDA C. REINSEH			2a. DATE OF DEATH MONTH 8 DAY 15 YEAR 87			2b. HOUR 7:20 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 10 YEAR 52		6. AGE (IN YEARS LAST BIRTHDAY) 35		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross HSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Robert MIDDLE F. LAST Shrader			15. MOTHER'S MAIDEN NAME FIRST Jerry MIDDLE L. LAST Thomas			16. STREET ADDRESS / ZIP CODE 2917 Parker Avenue 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-60-1586		17. INFORMANT Woodbridge, Va. 22192 Greg Holman (brother) 3452 Brookville Lane				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INFECTION DUE TO, OR AS A CONSEQUENCE OF (c) cirrhosis of liver APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS MONTHS - 7 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Renal insufficiency									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 23 , 19 87 , to Aug 16 , 19 87 , that (I) (we) last saw the deceased alive on Aug 15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard Gelfand				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Gelfand M.D.				22e. ADDRESS 5620 Shields Drive, Bethesda, MD 20817					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/18/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR AUG 19 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to arrive.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

03540 AUG 50 01

AUG 1 1951

062358 AUG 11 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24014

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Joseph Hinchman		Reitz				08				04		87		1:00AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		Caucasian		MONTH 03 DAY 08 YEAR 1897		90				YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Reitz Penna.		USA				Montgomery										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Olney		Montgomery General Hospital		Retired		Steel										Republic	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE									
Md.		Mont.		SilverSpr.				20906									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
John Henry		Charlotte		Gahagen													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT													
YES		WWI		190-05-0127		Joanne R. Blackstock		Laurel, Md.		20707							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senile Dementia</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>August 4</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED							
<u>John Vackee</u>		<u>M.D.</u>								8/4/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
John Vackee		10401 Old Georgetown Rd				Bethesda MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		8/7/87		McGregor Cemetery		Shade Township Somerset Pa.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
7601 Sandy Spring Rd.		AUG 10 1987				Julia Davidson-Randall											
Fleck Funeral Home, Inc.		Laurel, Md. 20707															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

BP

085328 AUG 11 81

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[Top section, possibly header or title area]

[Middle section, possibly body of text or data entries]

[Bottom section, possibly footer or signature area]

062991 AUG 18 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24015

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Clarissa A Eugenia Amour Rene</i>		2a. DATE OF DEATH MONTH DAY YEAR August 12, 8 1987		2b. HOUR 1015 PM
3 SEX <i>Female</i>	4 RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR 11 05 1922	6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Trinidad</i>	7b. CITIZEN OF WHAT COUNTRY? <i>Trinidad</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Residence: 10036 Forestview Place</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Gaithersburg</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>10036 Forestview Place (20878)</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>unknown</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eugenia Amour</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>131-50-7618</i>	17. INFORMANT <i>Gaithersburg, Maryland 20878</i> <i>Elva Rene (daughter) 10036 Forestview Place</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe neurologic disease and hypoxia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>July 4</i> 19 <i>87</i> to <i>August 12</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>7-23</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Philip J. Schwartz</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8-13-87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Philip Schwartz</i>	22e. ADDRESS <i>15225 Shady Grove Rd #206 Rockville, MD 20850</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Aug. 20, 1987</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mucurapo Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Saint James, Trinidad</i>	
24. FUNERAL DIRECTOR NAME <i>LATNEY's Funeral Home</i>		24b. DATE OF DEATH BY REGISTRAR <i>AUG 17 1987</i>		
24a. ADDRESS <i>3831 Georgia Avenue, NW, Washington, DC 20011</i>		24c. REGISTRAR'S SIGNATURE <i>Julia Dendron-Randall</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 50M 1/B1
(VIA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be distributed for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

005 001 100 200

063035 AUG 18 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) IDA E. RICHMAN						2a. DATE OF DEATH MONTH DAY YEAR 8/13/87		2b. HOUR 1255A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 23 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Cosmetic	
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 29 Ritchfield MD (20850)	
14. FATHER'S NAME FIRST MIDDLE LAST Morris Feldman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-16-4747		17. INFORMANT Beverly Goldman; Daughter; 29 Ritchfield Court, Rockville, Md. 20850					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) lung cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min 8 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 8/6 , 19 87 , to 8/13 , 19 87 , that (I) (we) lost saw the deceased alive on 8/12 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bruce A. Silver				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A. Silver, MD				22d. ADDRESS 106 Irving St., N.W., Washington, DC 20010					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/87		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Garden; Olney; Montgomery; Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25. DATE REC'D BY REGISTRAR AUG 17 1987					
1170 Rockville Pike; Rockville, Md. 20852									

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064578 SEP-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24017

REG. NO.

1. FOR
STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Lillian

Ritwo

3. DATE OF DEATH

MONTH

DAY

YEAR

24 Aug 87

2b HOUR

6:45 P.M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH

DAY

YEAR

10 6 03

6. AGE (IN YEARS LAST BIRTHDAY)

83

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

NEW JERSEY

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY CO. MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Kensington

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

10920 Connecticut Avenue, Apt. 319

14. FATHER'S NAME

Ike

MIDDLE

Greenberg

15. MOTHER'S MAIDEN NAME

Minnie

MIDDLE

Rahnos

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, ☐ NO ☒ UNKNOWN)

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

133-18-3906

17. INFORMANT

Gerald H. Ritwo 1121 Caddington Avenue Silver Spring, Md. 20901

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Aspiration pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Metastatic Carcinoma of the Breast

DUE TO, OR AS A CONSEQUENCE OF

(c)

4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Acute Gastritis, Renal Failure, fluid and electrolyte imbalance

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22. I certify that (I) (this hospital) attended the deceased from approx June 1987, to Aug 24, 1987 that (I) (we) last

saw the deceased alive on Aug 24 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above; (I) (we) (did) (did not) view the body after death.

23. SIGNATURE

DEGREE

22c. DATE SIGNED

Israel Spector MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

Aug 24 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Israel Spector MD

22e. ADDRESS

12001 Ferrara Avenue Wheaton Md 20906

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/26/1987

23c. NAME OF CEMETERY OR CREMATORY

New Montefiore

23d. LOCATION

Farmingdale, L. I., New York

DONOR: DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME

232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE RECEIVED BY REGISTRAR

AUG 28 1987

25b. REGISTRAR'S SIGNATURE

M. Anderson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any traumatic event, the medical examiner must be notified of once.

BP

REPORT TO THE

SECRETARY OF THE
NAVY
WASHINGTON, D. C.
1950

1. The purpose of this report is to provide a summary of the activities of the [illegible] during the period [illegible] to [illegible].

2. The [illegible] was organized on [illegible] and has since that time been engaged in the study of [illegible].

064485 SEP

1-207 FOR STATE REGISTRAR Unknown 87-92

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 24018

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED MONTH DAY YEAR		2b. HOUR	
Hector		Rivera						8-22		1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male	Cauc.	Mar. 18, 1965		22 YRS.						8-22		1987 4:00A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Puerto Rico		U.S.A.				Montgomery County						MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION, (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Suburban Hospital		Laborer		Factory							
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
New York		Kings		Brooklyn		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5602 4th Ave.		99999			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Hector R. Rivera		Justina Marciano											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT									
No		583-45-7777		Brooklyn, N.Y.		Justina Marciano		5622 4th Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
		1:30AM 8-22 1987		Passenger of vehicle in auto/fixed object collision									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
		Fair Grounds		Montgomery County Fairgrounds		Montgomery County, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 8-23-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201											
Charles P. Kokes, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Sept. 4, 1987		Rosedale		Linden, Union, N.J.							
24. PREDECESSOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
ROBERT C. ALTENBURG FUNERAL HOME, INC.		SEP 1 1987		Julia Swider-Rodriguez									
6009 Harford Rd., Balto., Md. 21214													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP

004482 284460

20% cotton 4.65

062156 AUG 10 1987

OR
STATE
- REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24019

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred J. Robey			2a. DATE OF DEATH MONTH DAY YEAR August 04, 1987		2b. HOUR 2:00a M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR September 24, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Wrapper	12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert I. Garber		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Phoutz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577 55 9692		17. INFORMANT (Son) ADDRESS William L. Robey 1919 Cherri Dr. Falls Church, Va. 22043	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH CAUSED BY.IMMEDIATE CAUSE (a) *metastatic carcinoma*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) *of the ovary*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>84</i> to <i>8-9</i> 19 <i>85</i> that (I) met <i>lost</i> saw the deceased alive on <i>8-3-1985</i> , and that in (my) own <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) was <i>did</i> view the body after death.			
22b. SIGNATURE <i>John F. Tauber, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED August 04, 1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Tauber, M.D.		22e. ADDRESS 8218 Wisconsin Ave. Bethesda Md. 20814	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE August 06, 1987	23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE New Windsor (Frederick) Maryland
24. FUNERAL DIRECTOR Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 7 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Davis</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24020 REG. NO.					
1- EOR STATE REGISTRAR		2. DECEASED NAME (BY PRINT)				3. DATE OF DEATH		4. MONTH		5. DAY		6. YEAR		7. HOUR	
		FIRST MIDDLE LAST Ellen M. Robicheau				8 27 87		0507		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. MONTHS		8. DAYS		9. HOURS		10. MIN.	
FEMALE		CAUCASIAN		MAY 23 97		90									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
MASSACHUSETTS		USA				MONTGOMERY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
TAKOMA PARK		WASHINGTON ADVENTIST				HOMEMAKER									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
MARYLAND				PR GEORGES		ADELPHI		YES <input type="checkbox"/> NO <input type="checkbox"/>		10133 RIGGS ROAD		20783			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST UNKNOWN BOWLES				FIRST MIDDLE LAST ALICE CULLEN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO				214-54-1420		DAUGHTER		122 SHIRLEY DRIVE		MARY WILLIAMS/ TABB, VIRGINIA 23602					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u>												<u>years</u>			
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Artery</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR P.M. 19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from <u>24 Aug</u> 19 <u>87</u> to <u>27 Aug</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>26 Aug</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
						27 Aug 87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Michael Leibovitch MD		1120 New Hampshire Ave SE, NE 20404													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
BURIAL		AUG 29, 1987		OUR LADY OF SORROWS		WEST RIVER		ANNE ARUNDEL				MD			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE							
NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901						SEP 02 1987		John L. ...							

 MEDICAL CERTIFICATION
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies (Pages 1 and 2) and file them with the State Dept. of Health and Mental Hygiene.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24022
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SUSAN H. ROSEN			2a. DATE OF DEATH MONTH DAY YEAR 8-8-87			2b. HOUR 2:45 PM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7-14-1894		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 93		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (COUNTRY) STATE OR FOREIGN MASS.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET-ADMINISTRATOR		12b. KIND OF BUSINESS OR INDUSTRY HADASSAH	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6121 MONTROSE RD 20852	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL HURWICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 007-20-5609		17. INFORMANT ADDRESS MRS M. GERI ROSEN 112 11th St. NE, WASH DC 20002	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ALZHEIMERS DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that this (this hospital) attended the deceased from 3/25 , 19 83 , to 8/8 , 19 87 , that (we) lost the deceased alive on 8/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.									
22b. SIGNATURE Alan F Chavales				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN F CHAVALLES				22e. ADDRESS 6121 MONTROSE Rd., ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8-10-1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, PG. C, MD.			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS Co.				ADDRESS RIVERDALE MD.		25. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE James Henderson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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063013 AUG 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24023

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY ALICE RUSSELL			2a. DATE OF DEATH MONTH DAY YEAR 8 9 87		2b. HOUR 9:20 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4 9 92		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Veterans Admin.
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry May		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margerite Miller		13e. STREET ADDRESS / ZIP CODE 14700 Peach Orchard Rd./20904	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-26-6915		17. INFORMANT 14700 Peach Orchard Road Charles E. Russell/Silver Spring, Maryland 20904	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 7-1-1987, to 8-9-1987, that (I) lost saw the deceased alive on 7-28-1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE John Tauber		DEGREE MD		22c. DATE SIGNED 8-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS 8218 Wisconsin Ave		MD. Bethesda	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8-10-87	23c. NAME OF CEMETERY OR CREMATORY Geo Wash U Med School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services			25a. DAY RECEIVED BY REGISTRAR AUG 17 1987		
225 Missouri Ave, NW Washington, DC 20011			25b. REGISTRAR'S SIGNATURE John Tauber		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24024
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles E. Russell			2a. DATE OF DEATH MONTH DAY YEAR 8-28-87			2b. HOUR 3AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 4, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		12b. KIND OF BUSINESS OR INDUSTRY Self-employed		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Sil Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph I Russell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Slick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-26-6915		17. INFORMANT 14700 Peach Orchard Road Everett Russell/Silver Spring, Maryland 20904					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Uremia, Sepsis, Hypothermia.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-1, 19 87, to 8-28, 19 87, that (I) (we) last saw the deceased alive on 8-27, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Tauber						DEGREE MD		22c. DATE SIGNED 8-28-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber						22e. ADDRESS Bethesda Md. 8218 Wisconsin Ave				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8-29-87		23c. NAME OF CEMETERY OR CREMATORY Geo Wash Med School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services 225 Missouri Ave, NW Washington, D.C. 20011						25a. DATE REC'D. BY REGISTRAR SEP 03 1987				

MEDICAL CERTIFICATION

064517 SEP-4-05

4

[Faint, mostly illegible handwritten text on lined paper, possibly a ledger or notebook page. Some words like "month" and "year" are faintly visible.]

SEP 20 1905

062073 AUG 8 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24025

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE RUSSO			2a. DATE OF DEATH MONTH DAY YEAR 8 1 87		2b. HOUR 10:00 P.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7 25 1890		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 7812 Horseshoe Lane 20854		14. FATHER'S NAME FIRST MIDDLE LAST John Currie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Euphemia Sillars		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 136-01-5394		17. INFORMANT ADDRESS Patricia R. Delafield same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YRS YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NEUROLOGIC RESIDUALS OF OLD STROKE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 9:00 , 19 84 , to 8/1 , 19 87 , that (I) (we) last saw the deceased alive on JULY 28 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Richard Delaney				DEGREE MD		22c. DATE SIGNED 8/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD R. DELANEY MD,				22e. ADDRESS 4323 HAVARD ST. SILVER SPRING MD 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda, Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR AUG 06 1987		25b. REGISTRAR'S SIGNATURE Julia D. ...	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, another medical certificate must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

063790 AUG 26 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24020
REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mollie			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1987			2b. HOUR 4:18p M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 02/27/-91		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Peter Dix			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Gregorius			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 397-07-6244			17. INFORMANT 535 Charington Drive Severna Park Md. 21146			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>13 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 10</u> 19 <u>87</u> , to <u>Aug 23</u> 19 <u>87</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Aug 23</u> 19 <u>87</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.									
22b. SIGNATURE Marian Chung, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIAN CHUNG				22e. ADDRESS 3701 Rossmore Blvd. Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 8/28/87		23c. NAME OF CEMETERY OR CREMATORY Hillside Lutheran Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Marshfield Wood Co. Wisconsin			
24. FUNERAL DIRECTOR NAME George Gonce				4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 24 1987 <u>John Landon</u>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the casket papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as "item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.")

063180 VNC 58 81



062870 AUG 17 1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24027

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK S. SAGONA, SR.			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 6, 1987			2b. HOUR 2:05P _M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 1, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1003 LANARK WAY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY WOODWARD &	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1003 LANARK WAY 20901	
14. FATHER'S NAME FIRST MIDDLE LAST SALVADOR SAGONA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONCETTA SEDITA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF U.S., GIVE WAR OR DATES) 1941-1945		17. INFORMANT DAUGHTER		ADDRESS 3 MEADOW ROAD NORTHBORO, MA 01532			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia with Cardiac arrest Immediate</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive & Arteriosclerotic Heart Disease 20 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (was hospital) attended the deceased from <u>15 Nov 1968</u> to <u>6 Aug 1987</u> , that (I) (was) last saw the deceased alive on <u>31 July 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Russell B. Arnold M.D.</u>						DEGREE M.D.		22c. DATE SIGNED <u>8/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUSSELL B. Arnold, M.D.				22e. ADDRESS 1106 Spring Street Silver Spring, Md. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE AUG 11, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE <u>John T. Anderson</u>			
500 University Blvd. W. Silver Spring, Md.									

MEDICAL CERTIFICATION

15350

229

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. The certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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063344 AUG 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24028

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MANUEL SANCHEZ-GUDIN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 15, 1987		2b. HOUR 9:35P M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 3, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN		7b. CITIZEN OF WHAT COUNTRY? CUBA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RESTAURATEUR		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4002 RICKOVER ROAD			12b. KIND OF BUSINESS OR INDUSTRY		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 4002 RICKOVER ROAD 20902					
14. FATHER'S NAME FIRST MIDDLE LAST EVARISTO SANCHEZ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOSEFA GUDIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-68-6755		17. INFORMANT ADDRESS MANUEL SANCHEZ/SON SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 30 , 19 86 , to AUGUST 15 , 19 87 , that (I) (we) last saw the deceased alive on JUNE 17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James Brodsky		DEGREE MD COVERING FOR Jose Guires, MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		22c. DATE SIGNED 8-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky, MD		22e. ADDRESS 4701 Willard Ave, Chevy Chase MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG18,1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD		24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			
25a. DATE REC'D. BY REGISTRAR AUG 20 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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064620 SEP -387

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24029

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Uriel H. Schoenbach			2a. DATE OF DEATH MONTH DAY YEAR 8 29 87		2b. HOUR 4 ⁴⁰ AM
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 21 23		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Wheaton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) info specialist	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4005 Wexford Drive, 20895	
14. FATHER'S NAME FIRST MIDDLE LAST ALVIN Fairbrook			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lotte Cohn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 206 16 7736		17. INFORMANT ADDRESS Caroline Schoenbach(wife) See #13 Above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor (GLIOMA)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 86, to August 29, 1987, that (I) (we) lost saw the deceased alive on August 29, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joel Kalman		DEGREE MD	22c. DATE SIGNED 8-29-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL KALMAN		22e. ADDRESS 6111 EXECUTIVE BLVD, ROCKVILLE MD 20152	

23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE Aug 31 1987	23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Ives-Pearson F. H. Falls Church, Va. 22046		25a. DATE REC'D. BY REGISTRAR SEP 02 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately taken to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Burial-transit permit 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

064850 SEP-3-81

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SEP 03 1981

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 4 0 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THELMA I SCHROEDER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 30 1987		2b. HOUR 9:20 A
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan 3 1901		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST N.C.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Dept. U.S. Navy
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Bannen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Blaisdell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223 22 7893		17. INFORMANT ADDRESS McLean, Virginia 22101 Florence M. Diehl, 1658 Quail Hollow Ct.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ATRIAL FIBRILLATION, POSSIBLE EMBOLIZATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from AUGUST 30 19 87 , to AUGUST 30 19 87 , that (2) I saw the deceased alive on AUGUST 30 19 87 , and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above; (4) (we) (did) not view the body after death.					
22b. SIGNATURE Alan R. Vinitzky		DEGREE MD		22c. DATE SIGNED 8/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN R. VINITZKY		22e. ADDRESS 12116 DARNESTOWN RD. GAITHERSBURG MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sep. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Maryland	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR SEP 3 1987			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.		25. DATE REC'D. BY REGISTRAR SEP 3 1987			
7557 Wisconsin Ave. Bethesda, Md. 20814					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

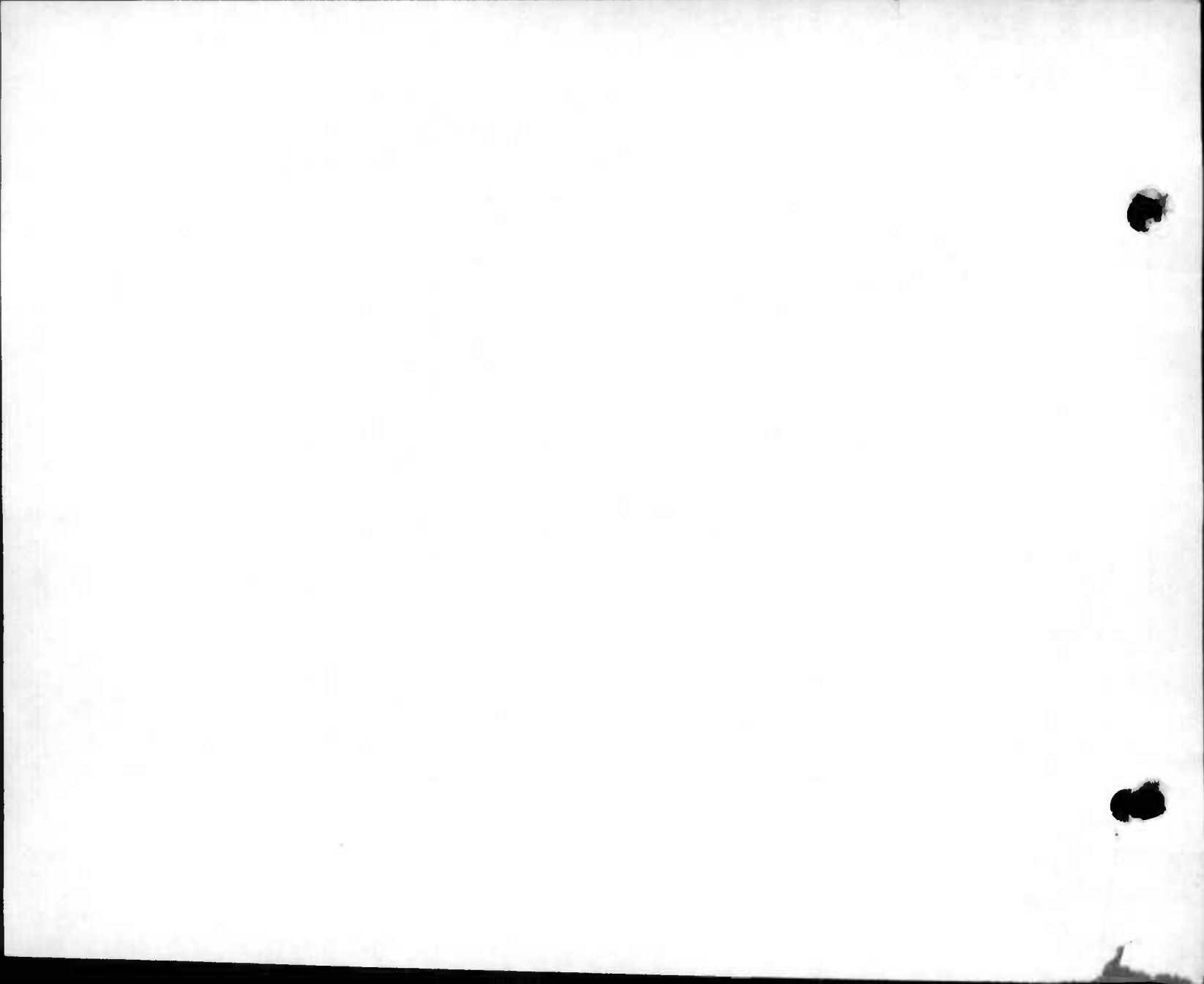
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

[Faint, illegible text, likely bleed-through from the reverse side of the page]

Void Death Certificate #87-24031



063256 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24032

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Berthelda W SEEMER</i>			2a DATE OF DEATH MONTH DAY YEAR <i>August 10, 1987</i>			2b HOUR <i>6:30 AM</i>			
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>April 2, 1900</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co.</i> MD.			
10 CITY OR TOWN OF DEATH <i>Kensington</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Circle Manor Nursing Home</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>home</i>		12b KIND OF BUSINESS OR INDUSTRY <i>home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <i>MD.</i>		13b COUNTY <i>Carroll</i>		13c CITY OR TOWN <i>Westminster</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <i>James Henry Williams</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>May Jackson Muire</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>na</i>		17 INFORMANT ADDRESS <i>Westminster, Md. 21157</i> <i>Marilyn M. Simons, 1805 Stone Chapel</i>					
18 CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia, right lower lobe</i> DUE TO, OR AS A CONSEQUENCE OF, (b) <i>Dehydration</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic cardiovascular disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>June 23, 1986</i> 19 <i>86</i> to <i>August 10</i> 19 <i>87</i> . saw the deceased alive on <i>August 10</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.									
22b SIGNATURE <i>Raymond Bradshaw, Jr. MD.</i>						DEGREE <i>MD.</i>		22c DATE SIGNED <i>Aug 10, 1987</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Raymond Bradshaw, Jr. MD</i>						22e ADDRESS <i>345 University Blvd, West Silver Spring, Md., 20901</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b DATE <i>8-13-1987</i>		23c NAME OF CEMETERY OR CREMATORY <i>Westminster</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Westminster Carroll MD</i>			
24 FUNERAL DIRECTOR NAME <i>Robert Kyle Pitts Jr. Westminster, Md</i>						25a DATE REC'D. BY REGISTRAR <i>AUG 17 1987</i>		25b REGISTRAR'S SIGNATURE <i>Julia Gordon-Rutman</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

063526 AUG 50 81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24033

FOR
1 - STATE
REGISTRAR

063461

AUG 21 1987

1. DECEASED NAME (TYPE OR PRINT) Rose Seidel		2a. DATE OF DEATH MONTH DAY YEAR August 15, 1987		2b. HOUR 4A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 18, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Grocer
13a. STATE Maryland		13b. COUNTY Prince Georges	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Purzitsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-52-4954		17. INFORMANT ADDRESS Philip B. Seidel (Same as # 13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral pneumonia</u> (c) <u>Chronic asperation</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>organic brain syndrome</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>11/28/1986</u> to <u>8/15/1987</u> that (1) (we) last saw the deceased alive on <u>8/14/1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (I) (us) (you) saw the body after death.					
22b. SIGNATURE <u>Charles M Benner MD</u>		DEGREE MD		22c. DATE SIGNED 8-15-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES M BENNER MD		22e. ADDRESS 11161 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/16/1987		23c. NAME OF CEMETERY OR CREMATORY Ezra's Israel Cong. Sec. Nat'l Cap'l Hebrew	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.		23e. DATE REC'D. BY REGISTRAR AUG 19 1987			
23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

083401 AUG 51 85

062577 AUG 13 87

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 4 0 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HERMAN JOSEPH SHECHTEL			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 7 1987		2b. HOUR MIN 12:12 ^A
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 17 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHEVY CHASE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS SHECHTEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELLA STEPANSKY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-1977		17. INFORMANT ADDRESS RETHA M. SHECHTEL, 8813 ALTIMONT LANE, CHEVY CHASE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 4 , 19 87 , to AUGUST 7 , 19 87 , that (I) (we) last saw the deceased alive on AUGUST 7 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Drew Lewis</i>		DEGREE MD		22c. DATE SIGNED 7 Aug 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. E. LEWIS, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 9, 1987	23c. NAME OF CEMETERY OR CREMATORY King David Men. Gd.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes		Arlington, Virginia 22201		25a. DATE REC'D. BY REGISTRAR AUG 11 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julie Anderson-Randall</i>	

MEDICAL CERTIFICATION

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35
301
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. They also may remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

065257 NOV 13 85

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AUG 1 1973

062714 AUG 14 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

coronal spine released case

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24035
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alonzo McKinley SIGLER			2a. DATE OF DEATH MONTH DAY YEAR 8/11/87			2b. HOUR 10:10PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 15, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY FREDERICK 13c. CITY OR TOWN LAMSVILLE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS AND CODE 10037 DR. PERRY RD. 21754		
15. FATHER'S NAME FIRST MIDDLE LAST JOHN MILTON SIGLER					16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH - JONES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-44-3458		17. INFORMANT ADDRESS ARLENE GANLEY SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal aspirated pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8/11/87	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								DUE TO, OR AS A CONSEQUENCE OF (b) - DUE TO, OR AS A CONSEQUENCE OF (c) -	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CVA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1985, 19, to 1987, 19, that (I) (we) last saw the deceased alive on 8/11/87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 8/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 7425 Arlington Rd Bethesda Md				22e. ADDRESS Dr. Osoth LEKAGUL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY LAYTONSVILLE		23d. LOCATION CITY OR TOWN COUNTY STATE LAYTONSVILLE MONT. MD.			
24. FUNERAL DIRECTOR MURIEL H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE James Davidson-Randall			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24036
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIVIAN V. SIMPSON			2a. DATE OF DEATH MONTH DAY YEAR 8-5-87			2b. HOUR 10:40 AM		
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 16 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL-BETHESDA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		
12b. KIND OF BUSINESS OR INDUSTRY Simpson & Simpson								
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 1131 University Blvd. 20902								
14. FATHER'S NAME FIRST MIDDLE LAST Joseph B. Simpson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Gaines		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16b. SOCIAL SECURITY NO. 213-38-3416		17. INFORMANT brother ADDRESS 9302 Long Branch Aubrey Simpson Pkwy. Silver Spring, MD 20901						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) severe chronic pulmonary disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/20 19 87 to 8/5 19 87, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Julia S. Levin		DEGREE Covering Physician ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-5-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheila Levin		22e. ADDRESS 9715 Medical Center Dr. Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Aug 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. W Silver Sprig, MD 20901				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24037

REG. NO.

DECEASED NAME FIRST MIDDLE LAST WILLIAM SISKIND			2a. DATE OF DEATH MONTH DAY YEAR Aug. 15, 1987		2b. HOUR 8:08A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 7, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 68	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3535 Chevy Chase Lake Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY Dept. of Energy	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Siskind			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Singer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-01-6706	17. INFORMANT Ruth A. Siskind		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>PANCREATIC CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mo/ps					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Daniel Rosenblum		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM		22e. ADDRESS 10400 CONNECTICUT AV KENSINGTON, MD 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 17, 1987	23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gds.		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland
24. FUNERAL DIRECTOR NAME Ives Pearson Funeral Homes, Arlington, Va.			25. DATE REC'D BY REGISTRAR AUG 18 1987		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by a physician within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by John F. Tauber, M.D. 8-19-87

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24038 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) M. Mayhall Smith										2a. DATE OF DEATH MONTH DAY YEAR August 19, 1987		2b. HOUR 6:00AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 21, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5805 Jarvis Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.							
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5805 Jarvis Lane 20814	
14. FATHER'S NAME FIRST MIDDLE LAST John Hickson Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Bell Robison									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 318-05-3787		17. INFORMANT ADDRESS Alvina N. Smith Wife same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous cell carcinoma of esophagus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this examined) attended the deceased from <u>January 24,</u> 19 <u>86</u> to <u>August 19,</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>May 22,</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.													
22b. SIGNATURE <i>Donna Rinis M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Aug. 19, 1987					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donna Rinis, M.D.				22e. ADDRESS 11510 Old Georgetown Rd., Rockville, Md. 20852									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 21, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Maryland							
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Twiss-Randall</i>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24039
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1b. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
REBECCA N. SMITH		Aug. 2, 1987		8 15 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Black	Dec. 25, 1889	97	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	USA		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Olney	Brooke Grove Nursing Home		Waitress		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Montg.	Olney	YES <input type="checkbox"/> NO <input type="checkbox"/>	18201 Marden Lane / 20832	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST Joseph Newsome			FIRST MIDDLE LAST Ida Stewart		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		216-09-4703	335 Lincoln Ave., Rockville, MD Lillian Brown (sister-in-law)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION OF FOREIGN BODY</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>October 19 86</u> to <u>AUGUST 19 87</u> , that (I) (we) last saw the deceased alive on <u>7-13</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>J. E. Howe, MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>8/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>TEDE. HOWE.</u>		<u>18430 BROOKE GROVE Rd. Olney, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		8-6-87	Lincoln Park Cem.		Rockville, Montg, MD
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
George R. Snowden Rockville, MD 20850			<u>AUG 05 1987</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene and to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24040

REG. NO.

1. DECEASED NAME (LAST, FIRST, MIDDLE) <i>Benjamin L. Souther</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8-22-87</i>			2b. HOUR MIN. SEC. <i>12:10 PM</i>				
3. SEX <i>Male</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9-15-94</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>92</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. SEC.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>SOUTH DAKOTA</i>		9. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY COUNTY MD</i>				
12. CITY OR TOWN OF DEATH <i>SILVER SPRING</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HOLY CROSS HOSPITAL</i>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CHEMIST/TEACHER</i>		15. KIND OF BUSINESS OR INDUSTRY <i>F.M.C.</i>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <i>MD.</i>			16b. COUNTY <i>HOWARD</i>			16c. CITY OR TOWN <i>ELLICOTT CITY</i>			16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17. FATHER'S NAME FIRST MIDDLE LAST <i>HENRY WARD BECKER SOUTHER</i>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY ELLA SOUTHER</i>			19. STREET ADDRESS / ZIP CODE <i>9953 CARRIGAN DR. 21043</i>				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>YES WWI</i>			21. SOCIAL SECURITY NO. <i>041-14-1524</i>			22. INFORMANT ADDRESS <i>GRACE E. SOUTHER 385 W. UNIVERSITY PKWY. BALD. MD. 21210</i>				
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>URFRIA Gastro-Intestinal Hemorrhage.</i>										
24. DATE OF OPERATION			25. CONDITION FOR WHICH OPERATION WAS PERFORMED			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE				
34. I certify that (I) (the hospital) attended the deceased from <i>2-3</i> , 19 <i>87</i> , to <i>8-22</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8-22</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.										
35. SIGNATURE <i>Morton A. Gschuler MD</i>						36. DEGREE <i>MD</i>		37. DATE SIGNED <i>8/22/87</i>		
38. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Morton A. Gschuler MD</i>						39. ADDRESS <i>1299 - L Annapolis Dr. Silver Spring Md. 20862</i>				
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>			41. DATE <i>25 AUG 87</i>			42. NAME OF CEMETERY OR CREMATORY <i>WESTVIEW MEM. PK.</i>			43. LOCATION CITY OR TOWN COUNTY STATE <i>CATONSVILLE BALD. MD</i>	
44. FUNERAL DIRECTOR NAME <i>Shack Funeral Home</i>						45. ADDRESS <i>Ellicott City, Md. 21037</i>			46. DATE REC'D. BY REGISTRAR <i>SEP 03 1987</i>	
47. REGISTRAR'S SIGNATURE <i>John Swanson-Randall</i>										

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

064133 SEP 4 1961

063670 AUG 25 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24041

REG. NO.

1. DECEASED NAME (Type or Print) James P Spellman			2a. DATE OF DEATH MONTH DAY YEAR August 19 1987			2b. HOUR 9²¹ AM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 27, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 43		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASSIST VP		12b. KIND OF BUSINESS OR INDUSTRY SETTLEMENT CO.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10609 WHEATLEY STREET 20895	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH SPELLMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN FAIRBURN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 189-34-4052		17. INFORMANT ADDRESS MARY C. SPELLMAN/WIFE SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding from Esophageal Varices DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of Liver								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hour Days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 19 1987 to Aug 19 1987 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on August 19 1987 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.									
22b. SIGNATURE Patricia D Kellogg MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA D. KELLOGG				22e. ADDRESS 809 Veirs Mill Rd, Rockville, Md 20851					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG22, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901				25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE Julia T. Anderson-Randall			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled out by the funeral director. Page 3 should be detached for use on the burial transit permit. Then please remove carbon copy of page 3 and 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

03810 JMC 52 81

AUG 24 1981

063286 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24042
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Benjamin H. Spotts SR.			2a DATE OF DEATH MONTH DAY YEAR 08-15-87		2b HOUR 10:45 PM
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 04 13 13		6. AGE (IN YEARS LAST BIRTHDAY) 74	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) service station		12b KIND OF BUSINESS OR INDUSTRY private
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md			13b CITY OR TOWN Montgomery		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George Spotts			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thomas Mabry Smith		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 249-05-3357		17 INFORMANT ADDRESS Silver Spring Md Ruby W. Spotts 13805 Castle Blvd #12 20904	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma Colon</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8.3</u> 19 <u>87</u> to <u>8.15</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8.15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rajindra K. Sarin M.D.				22c. DATE SIGNED 8/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJINDRA K. SARIN				22e. ADDRESS 9801 Ga Ave Silver Spring MD 20902	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 8/18/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George Md		24 FUNERAL DIRECTOR Donald V. Borgwardt 4400 Powder Mill Rd Beltsville Md 20705			
25a. DATE REC'D. BY REGISTRAR AUG 19 1987				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be having a chance.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

08358 AUG 30 84

065639 SEP 15 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24043
REG. NO.

1. DECEASED NAME (PRINT) Margaret FRABER Stafford		2a. DATE OF DEATH MONTH August DAY 31 YEAR 87		2b. HOUR 2:30 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH February DAY 16 YEAR 1911	6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHEVY CHASE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9200 Jones Mill Road 20815	
14. FATHER'S NAME FIRST WILLIAM MIDDLE LAST FRABER		15. MOTHER'S MAIDEN NAME FIRST HELENA MIDDLE LAST SULLIVAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-44-7407		17. INFORMANT ADDRESS OLIVER E. STAFFORD HUSBAND SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anemia DUE TO, OR AS A CONSEQUENCE OF (b) Peranicious Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) dehydration					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) 			
21d. INJURY OCCURRED WHERE: <input type="checkbox"/> AT HOME <input type="checkbox"/> IN WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 			
22a. I certify that (I) (this hospital) attended the deceased from 19 78 to 31 Aug 87 , that (I) (we) last saw the deceased alive on 31 Aug 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Merton L. White		DEGREE M.D.		22c. DATE SIGNED 31 Aug 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Merton L. WHITE, M.D.		22e. ADDRESS 9911 Georgia Ave Silver Spring, MD 20903			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE SEPT. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONTGOMERY STATE MD.		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901			25a. DATE RECD. BY REG. NO. SEP 14 1987 25b. REGISTRAR'S SIGNATURE Julia D. R. R. R.		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 4 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

002030 SEP 12 61

SEP 14 1961

063370

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Item 16b, film G631, 9-1
1- STATE REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Anna Helen Stark			2a. DATE KNOWN OF DEATH ESTIMATED Aug 4 1987			7b. HOUR 5:58		
4 RACE E W			5 DATE OF BIRTH MONTH DAY YEAR JULY 26, 1898 89			6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 89 YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10 CITY OR TOWN OF DEATH Sil. Spg			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2017 Franwall Ave			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		
13a STATE MD			13b COUNTY Mont.			13c CITY OR TOWN Sil. Spg		
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH YURECK			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA AFTON			16 SOCIAL SECURITY NO. 185-05-4800 205-14-4606		
17a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			17b INFORMANT DAUGHTER			17c ADDRESS 2017 FRANWALL AVE. SILVER SPRING, MD 20902		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None								
19a DATE OF OPERATION None			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John Rogers			TITLE (SPECIFY) M.D.			DATE Aug 11 1987		
EXAMINER'S NAME (TYPE OR PRINT) JOHN ROGERS			ADDRESS 1919 SEMINARY ROAD SILVER SPRING, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE AUG 14, 1987		23c NAME OF CEMETERY OR CREMATORY OUR LADY OF GRACE		23d LOCATION CITY OR TOWN COUNTY STATE MIDDLE TWSP BUCK PENNSYLVANIA	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.			25a DATE REC'D. BY REGISTRAR AUG 20 1987			25b REGISTRAR'S SIGNATURE John Rogers		
ADDRESS 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901								

07/84
25M

BP
DHMH : 17
(VR A15 ME (5))

003310 WES 51 81

NOTICE

CHIEF

061832 AUG 5 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 24045

1 DECEASED NAME (TYPE OR PRINT) Margaret A. Staub			2a DATE KNOWN OF DEATH ESTIMATED Aug 19 1987			2b HOUR 3:12 PM		
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH May DAY 10 YEAR 1921	6 AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	7c DATE PRONOUNCED DEAD Aug 19 1987	7d HOUR 3:12 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? American		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE MD				13b COUNTY Montgomery		13c CITY OR TOWN Baltimore		
14 FATHER'S NAME FIRST Harvey MIDDLE R. LAST Gue		15 MOTHER'S MAIDEN NAME FIRST Phebe MIDDLE V. LAST Humerick		13d INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 23212 Ridge Rd		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-40-6020		17 INFORMANT Luther F. Staub		ADDRESS Item 13		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial DKA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		
		21f LOCATION STREET CITY OR TOWN COUNTY STATE		

22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE **J. L. Rogers** TITLE (SPECIFY) **M.D.** MEDICAL EXAMINER DATE SIGNED **Aug 2, 1987**

EXAMINER'S NAME (TYPE OR PRINT) ADDRESS

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 8/5/87	23c NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park	23d LOCATION CITY OR TOWN Rockville COUNTY Montg. STATE Md.
24 FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md. ADDRESS		25a DATE REC'D. BY REGISTRAR AUG 4 1987	25b REGISTRAR'S SIGNATURE Julia Davidson-Kendall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD, "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24040

FOR
1- STATE
2- REC'D
SEP-2-87
1- DECEASED NAME
(TYPE OR PRINT)

1- DECEASED NAME (TYPE OR PRINT) <i>Phillip H. Steinberg</i>		2a DATE KNOWN OF DEATH MATED <i>Aug 23 1987</i>		2b DATE KNOWN OF DEATH MATED <i>Aug 23 1987</i>	
3 SEX <i>Male</i>	4 RACE <i>White</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>Dec 11 31 55</i>	6 AGE (IN YEARS) LAST BIRTHDAY <i>31</i>	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>	7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
7c DATE PRONOUNCED DEAD <i>Aug 23 1987</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10 CITY OR TOWN OF DEATH <i>Sil. Spg.</i>		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hosp</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Professor</i>	
12b KIND OF BUSINESS OR INDUSTRY <i>College</i>		13a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Mont.</i> 13c. CITY OR TOWN <i>Sil. Spg.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Harry Steinberg</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fannie Simpkin</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>	
16b SOCIAL SECURITY NO. <i>281-30-2149</i>		17. INFORMANT ADDRESS <i>Carol Steinberg (Same as # 13)</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Chronic Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>					
19a DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. <i>Dept.</i>		DATE SIGNED <i>Aug 23 1987</i>	
EXAMINER'S NAME (TYPE OR PRINT)		23a. NAME OF CEMETERY OR CREMATORY <i>King David Mem. Garden</i>			
23b. DATE <i>8/26/1987</i>		23c. LOCATION CITY OR TOWN COUNTY STATE <i>Falls Church, Virginia</i>		23d. DATE REC'D BY REGISTRAR <i>AUG 28 1987</i>	
23e. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>		23f. REGISTRAR'S SIGNATURE			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM-PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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AUG 24 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24047

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESBER BARNES STOKES			2a. DATE OF DEATH MONTH DAY YEAR August 19, 1987		2b. HOUR 9:00P M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 27, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Conv. & Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE North Carolina	13b. COUNTY Nash	13c. CITY OR TOWN Spring Hope	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE General Delivery 27882	
FATHER'S NAME FIRST MIDDLE LAST William Barnes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charity Humphry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Barbara Bushrod/Daughter/ 1763 Sycamore St, NW Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 10/16 19 86 to 8/19 19 87 , that (I) (we) last saw the deceased alive on 8/19 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <i>Myron L. Lenkin</i>		DEGREE		DATE SIGNED 8/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Myron L. Lenkin, M.D.		22e. ADDRESS 2305 Shorefield Drive, Wheaton, Md 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1987 August 24,	23c. NAME OF CEMETERY OR CREMATORY Stokes Family Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Middlesex North Carolina		
24. FUNERAL DIRECTOR NAME William Toney's Funeral Home ADDRESS 516 Poplar St., Spring Hope, N.C. 27882			25a. DATE REC'D. BY REGISTRAR AUG 21 1987		

MEDICAL CERTIFICATION

003424 WGS 54 81

James A. Smith

James A. Smith

62555 AUG 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, attend to a coroner or medical examiner.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24048

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Helen E. Stoll		August 5, 1987		4:15p M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	91	IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Alaska		United States		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Wheaton		Manor Care Wheaton		Restaurant Owner	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Bethesda	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.	
Carl		Anna		579-18-9896	
17. INFORMANT		17. ADDRESS		17. ADDRESS	
Charles J. Rose (Attorney)		Suite #829		1511 K. Street N.W. Washington, D.C. 20005	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:				Immediate	
IMMEDIATE CAUSE (a) Cardiac Arrest					
DUE TO, OR AS A CONSEQUENCE OF				5 Minutes	
(b) Massive Acute Myocardial Infarction					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1983, to July 21, 1987, that (I) (we) last saw the deceased alive on July 21, 1987, and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
DEGREE				August 6, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
John Wyman M.D.				7801 Norfolk Avenue Bethesda, Maryland 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		August 8, 1987		Cedar Hill Cemetery	
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE	
NAME		AUG 11 1987		Julia Gordon-Randall	
7557 Wisconsin Avenue Bethesda, Maryland 20814					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24049	
FOR THE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PAUL BERTRAM STREETER						2a. DATE OF DEATH MONTH DAY YEAR AUGUST 8 1987		2b. HOUR 10:24 AM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 11, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phillipsburg N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Super Swift & Co visor		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY PR George		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2816 Viceroy Ave 20747			
14. FATHER'S NAME FIRST MIDDLE LAST Guyger T. Streeter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Shiye							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 171-09-0639		17. INFORMANT ADDRESS Elsie D. Streeter Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN STEM CEREBROVASCULAR ACCIDENT										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 DAYS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 DIABETES MELLITUS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from JULY 30, 1987, to AUGUST 8, 1987, that (I) (we) last saw the deceased alive on AUGUST 7, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert H. Richman				DEGREE M.D.				22c. DATE SIGNED AUGUST 8 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Richman M.D.				22e. ADDRESS 7733 ARKLA AVENUE NW WASHINGTON D.C. 20012							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11 Aug 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md					
24. FUNERAL DIRECTOR NAME Robert E Wilhelm				ADDRESS Funeral Home Suitland, Md.		25. DATE RECEIVED BY REGISTRAR AUG 14 1987					

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064646 SEP 3 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24050

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Emma B. Stumph			2a. DATE OF DEATH MONTH DAY YEAR 8/27/87			2b. HOUR 7:55 PM				
3. SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 19 89		6 AGF (IN YEARS LAST BIRTHDAY) 98 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE #224 8811 COLESVILLE ROAD 20910	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH STUMPH			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA C. ROTH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-68-7098			17 INFORMANT ADDRESS MARGARET STUMPH/SISTER SAME AS 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic Cardio-Vascular Disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/27/87 to 8/27/87 , that (I) (we) lost saw the deceased alive on 8/27/87 at 8:00 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Myron L. Lenken			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKEN			22e. ADDRESS 2309 SHOREFIELD WAREHON MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG 29, 1987		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901						25a. DATE REC'D BY REGISTRAR SEP 02 1987				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the attending physician must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return it to the funeral director. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

BP _____

001-016-23-3-61

2

Charles A. [unclear]

with [unclear] [unclear]

to [unclear] [unclear]

Wm. [unclear]

211 OS [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low number of the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24051

REG. NO.

1 - FOR
STATE
REGISTRAR

DECEASED NAME (FIRST MIDDLE LAST) TILLIE SUGAR.			2a. DATE OF DEATH MONTH DAY YEAR 8-16-87		2b. HOUR 130 P
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-5-1898		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Wash.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13e. STREET ADDRESS / ZIP CODE 10002 Branch View Court 20903		
14. FATHER'S NAME (FIRST MIDDLE LAST) (Unknown)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Ruth (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-60-7123		17. INFORMANT ADDRESS Rosellen Fleming (Same as # 13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Dementia Alzheimers 6 years DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-18 , 19 87 , to 8-16 , 19 87 , that (I) (we) last saw the deceased alive on 8-16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Loretta J. Albiol, MD		DEGREE MD		22c. DATE SIGNED 8-17-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETO J. ALBIOL		22e. ADDRESS 6121 MOUNT ROSE RD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/1987		23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon	
23d. LOCATION CITY OR TOWN Hyattsville, P. G., Md.		23e. DATE REC'D. BY REGISTRAR AUG 21 1987		23f. REGISTRAR'S SIGNATURE [Signature]	
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					

BP

023815 W02 50 03

20% COLLOR FILTER

11/11/2003

11/11/2003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VIA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24052
REG. NO.1 - FOR
STATE
REGISTRAR

AUG 25 87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth M. Swab</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>8-18-1987</i>				2b. HOUR <i>6:55 A.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 25 41</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>46</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Tokoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>COMPUTER OPER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>PRIVATE BUSINESS</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1707 Myrtle Rd 20902</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ROGER F. MUSY</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MILDRED MEYER</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <i>NO</i>		16b. SOCIAL SECURITY NO. <i>280-36-4314</i>		17. INFORMANT ADDRESS <i>JAMES R. SWAB/HUSBAND SAME AS 13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Breast cancer with hepatic metastasis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs. 3 mos.</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>83</i> , to <i>Aug</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8-17</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wei Z. Zhang, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8-18-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kai-Yin YEUNG, M.D.</i>				22e. ADDRESS <i>8826 Woodyard Road #201, Clinton, MD 20725</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>AUG 21, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD</i>			
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR.</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 24 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			
500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901									

BP _____

3204 AUG 22 01

RECEIVED
OFFICE OF THE
DIRECTOR
AUG 22 1901

RECEIVED

AUG 24 1901

BP

DHMM - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, after signing the carbon copy, page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

#14 15, per F.H. 8/10/87 kam		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		24053 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FANNIE SWISS			2a. DATE OF DEATH MONTH DAY YEAR 8-5-87 2b. HOUR 4:15 AM		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3-30-1892		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR OWN HOME
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND MONTGOMERY ROCKVILLE			13b. STREET ADDRESS / ZIP CODE 6121 MONTROSE ROAD 20852		
14. FATHER'S NAME : 4. : 9:25T Baruch Eleazer Oshinko			15. MOTHER'S MAIDEN NAME IRST AIDDI Chaya Goldstein		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 063-24-6675		17. INFORMANT SALLY PERLBERG, 11015 BURNLEY TERRACE SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Dementia Alzheimer's					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 2-14 19 87 to 8-5 19 87 that (I) <input checked="" type="checkbox"/> saw the deceased alive on 8-5 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) not view the body after death.					
22b. SIGNATURE Loreto S. Albiol, MD		DEGREE MD		22c. DATE SIGNED 8-5-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETO S. ALBIOL MD		22e. ADDRESS 6121 MONTROSE Rd.			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8/6/1987		23c. NAME OF CEMETERY OR CREMATORY CEDAR PARK CEMETERY	
				23d. LOCATION WESTWOOD COUNTY NEW JERSEY	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR AUG 07 1987	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

085518 MAY 11 95

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062485

AUG 13 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24054

FOR
1- STATE
2- COUNTY
3- CITY OR TOWN

1. DECEASED NAME
(TYPE OR PRINT)

FIRST **Rose**MIDDLE **Dezelan**LAST **Tash**

2a. DATE KNOWN OF DEATH ☐ MONTH ☐ DAY ☐ YEAR ☐ HOUR
2b. DATE ESTI- MATED **Aug 7 1987** ☐ MONTH ☐ DAY ☐ YEAR ☐ HOUR

3 SEX

Female

4 RACE

White

5. DATE OF BIRTH

April 24 1975

6 AGE (IN YEARS)

12 YRS.

1f UNDER 1 YR.

MONTHS

1f UNDER 24 HRS.

HOURS

2c. DATE PRONOUNCED DEAD

Aug 7 1987

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

PA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

8800 Coleville Rd. Silver Spring, MD

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Owner

12b. KIND OF BUSINESS OR INDUSTRY

Theaters

13a. STATE

MD

13b. COUNTY

Mont

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

8800 Coleville Rd. Silver Spring, MD

4. FATHER'S NAME

(Unknown)

MIDDLE

Dezelan

LAST

15 MOTHER'S MAIDEN NAME

(Unknown)

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

153-10-6272

17. INFORMANT

Sandra Weltman 2231 Bancroft Pl. NW Wash., DC 20008

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

None

20 AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE

TITLE (SPECIFY)

M.D.

MEDICAL EXAMINER

DATE SIGNED **Aug 9, 1987**

EXAMINER'S NAME (TYPE OR PRINT)

1919 Seminary Rd. Silver Spring, MD 20910

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/12/87

23c. NAME OF CEMETERY OR CREMATORY

Nat'l. Mem. Park Cem.

23d. LOCATION

Falls Church, VA

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Joseph Gawler's Sons, Inc.

ADDRESS

5130 WI Ave. NW Wash., DC 20016

25a. DATE REC'D. BY REGISTRAR

AUG 12 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM-3 (RETAIL) PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

062482 AUG 13 87

None

Person

Flash

White

Female

FA

U.S.A.

Owner

Telephone

(Unknown)

Person

(Unknown)

No

155-10-5275

Sanctus Velian SSJ1 Rotoroff PI. 1M

Wash., DC 20008

1979 Gemini 10. Silver Spring, MD 20910

2330 W. Ave. NW Wash., DC 20008

Lowell Avenue, Inc.

06/20/87

Int'l. New. Park Coll.

Willa Church, VA

AUG 13 1987

Dr. Rogers ok'd Dr. Goozh to sign cert.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24055

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gerald A. Tatum			2a. DATE OF DEATH MONTH DAY YEAR 08 13 87		2b. HOUR 2224 M
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 31 39		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY hospital
13a. STATE Maryland		13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Tatum		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Seymour		13e. STREET ADDRESS / ZIP CODE 8508 16th Street 20910	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578 52 6209		17. INFORMANT Ponise Tatum ADDRESS 8508 16th St #404 Sil Sp MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN STEM MENINGIOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEPT 85					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (the hospital) attended the deceased from 10 AUG 1987 to 13 AUG 1987 that (I) (we) last saw the deceased alive on 10 AUG 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22a. SIGNATURE Walter E. Goozh MD DEGREE				22c. DATE SIGNED 18 AUG 87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 18, 1987		23c. NAME OF CEMETERY OR CREMATORY Harmony	
23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland P.G.		25a. DATE REC'D. BY REGISTRAR AUG 24 1987			
24. FUNERAL DIRECTOR NAME ADDRESS McGuire Funeral Service 7400 Ga. Ave, N.W.		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

30
064068 AUG 28 1987STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24056
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BEATRICE E TEAR			2a. DATE OF DEATH MONTH DAY YEAR 8/21/87			2b. HOUR 0601 A M																	
3. SEX F		4. RACE CA.		5. DATE OF BIRTH MONTH DAY YEAR 03 02 05			6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.														
10. CITY OR TOWN OF DEATH MONTGOMERY CO.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. ADVENTIST HOSP.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LIBRARIAN			12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT											
13a. STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN TAKOMA PK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 720 KENNEBEC AV 20912														
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL AMBROSE TEAR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLE CULP			16. SOCIAL SECURITY NO. 217 44 3093						17. INFORMANT GERTRUDE ROEMER - COUSIN											
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 44 3093			19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF Endometrial Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Senile Dementia (c) Years						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None																							
19a. DATE OF OPERATION 10 Aug 87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Endometrial Carcinoma Cholelithiasis						20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (1) (this hospital) attended the deceased from 3 Aug 87 to 21 Aug 87 , that (1) (we) lost saw the deceased alive on 21 Aug 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) not view the body after death.												22b. SIGNATURE [Signature]						22c. DATE SIGNED 21 Aug 87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibman MD						22e. ADDRESS 1120 Myrtle St, Md 20904																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8-22-87			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE														
24. FUNERAL DIRECTOR NAME State Anatomy Board						ADDRESS Balto., Md.						25a. DATE REC'D. BY REGISTRAR AUG 27 1987			25b. REGISTRAR'S SIGNATURE [Signature]								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

00 40 33 30 30 80

065209 SEP 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Properly completed, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified through the coroner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										24057 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Frederick Frederick Herbert Thomas						2a. DATE OF DEATH MONTH DAY YEAR 08 29 87				2b. HOUR 1659 M			
3. SEX Male		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 11 10 99		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) United Kingdom		9b. CITIZEN OF WHAT COUNTRY? United Kingdom		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Takoma Park MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Minister					
13a. STATE Michigan		13b. COUNTY Berrien		13c. CITY OR TOWN Berrien Sp.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8663 Meadowlark LA 49103					
14. FATHER'S NAME FIRST MIDDLE LAST Tom Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Hopkins Powell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Frederick Thomas		17. ADDRESS 7129 Carriage Hill Dr Laurel MD 20707							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> , 19 <u>87</u> , to <u>8/29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Kirkland C. Brance</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND C. BRANCE						22e. ADDRESS 1600 Carroll Ave, Takoma Park, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/2/87		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi PG MD							
24. FUNERAL DIRECTOR Fleck Funeral Home Inc 7601 Sandy Spring Rd Laurel MD 20707						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE SEP 9 1987 <u>John Anderson-Rudman</u>					

062508 SEP 10 87

10

063247 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24058

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Joseph George Thomas			2a DATE OF DEATH MONTH DAY YEAR 8-15 8-15-87		2b HOUR 1314 M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Rockville	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 1405 Viers Mill Road 20851
14 FATHER'S NAME FIRST MIDDLE LAST George Joseph Thomas		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Selfert			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17 INFORMANT Nan B. Thomas (wife) same as 13e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>8/12</u> , 19 <u>87</u> , to <u>8/15</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <u>Barry S. Talesnick MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/15/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) BARRY S. TALESNICK MD		22e ADDRESS 9711 Medical Center Drive Rockville MD 20851			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 8/18/87	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24 FUNERAL DIRECTOR'S NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852		25a DATE REC'D BY REGISTRAR AUG 19 1987		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

064205 AUG 31 1987

Items, 18a., 22a., G-631, by Med. Exam., STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24059
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			7b. HOUR							
Peter			Matthew			Thomas			8 17 19 87			AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR					
MALE		WHITE		2/19/54		33 YRS.		MONTHS DAYS		HOURS MIN.		8 17 19 87		1:43 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
WEST VIRGINIA				U.S.A.								Montgomery County MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Takoma Park				Washington Adventist Hospital				COMPUTER PROGRAMMER GOVT.											
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND												MONTGOMERY		8815		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8815 ARLISS ST. 20901	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
JAMES						THOMAS						MARY GERALDINE KENNEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						16c. ADDRESS							
YES, NO, OR UNKNOWN						(IF YES, GIVE WAR OR DATES)													
NO						N.A.						UNKNOWN							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Fatty change of liver 4																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) Ethanolism																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE							
								STREET											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion																			
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>																			
Actual Signature: <i>Dennis F. Smyth</i> M.D. Assistant MEDICAL EXAMINER DATE SIGNED: 8/18/87																			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS: 111 Penn St. Balto.MD.																			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
BURIAL				8/20/87		ST. MICHAEL'S CEM.				FROSTBURG, ALLEGANY MD									
24. FUNERAL DIRECTOR: <i>Michael M. Sowers</i> ADDRESS: 60 W. MAIN ST. FROSTBURG, MD																			
25a. DATE REC'D. BY REGISTRAR: AUG 28 1987 25b. REGISTRAR'S SIGNATURE: <i>Davidson-Randall</i>																			

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THE PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGE 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25MDHMH - 17
(VR A15 ME (5))

004502 JUN 21 81

DEPT OF COMMERCE

U.S. DEPARTMENT OF COMMERCE



U.S. DEPT. OF COMMERCE

062552 AUG 18 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 states any injury or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24060

REG. NO.

DECEASED NAME (TYPE OR PRINT) Dr. THEODORE B. TIHANSKY			DATE OF DEATH MONTH DAY YEAR AUGUST 7, 1987			HOUR 6:55 PM			
SEX MALE		RACE WHITE		DATE OF BIRTH MONTH DAY YEAR AUGUST 19, 1916		AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
BIRTHPLACE (COUNTRY) PENNSYLVANIA		CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD			
CITY OR TOWN OF DEATH BETHESDA		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER				USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN		KIND OF BUSINESS OR INDUSTRY MEDICAL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PENNSYLVANIA 13b. COUNTY SCHUYLKILL 13c. CITY OR TOWN PINE GROVE			INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		STREET ADDRESS / ZIP CODE R.D. 2, BOX 94H / 17963				
FATHER'S NAME FIRST MIDDLE LAST WASIL TIHANSKY			MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BAVOLACK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW 11 182-36-3839		17. INFORMANT WIFE ADDRESS MRS. ANN B. TIHANSKY (SAME AS ABOVE)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multi system organ failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immunologic Disorder - unknown DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks 8 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 26 , 19 87 , to AUGUST 7 , 19 87 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 7 , 19 87 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alan G.D. Hoffman, MD						DEGREE MD		22c. DATE SIGNED Aug 7, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ALAN G.D. HOFFMAN						22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUGUST 12, 1987		23c. NAME OF CEMETERY OR CREMATORY CHARLES BABER CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE POTTSVILLE, PENNSYLVANIA		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOME / BETHESDA-CHEVY CHASE, INC 7557 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814						25a. DATE REC'D BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE Julia Dendron-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24061

REG. NO.

FOR
1 - STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

Floyd WALTER Trammell, JR.

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
8 18 87 2:40 P

3 SEX

male

4 RACE

white

5. DATE OF BIRTH

MONTH DAY YEAR
5 13 41

6 AGE (IN YEARS LAST BIRTHDAY)

46

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WASHINGTON, DC

7b CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery Co. MD

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Holy Cross Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

PAINTER

12b KIND OF BUSINESS OR INDUSTRY

DEPT. OF FEDERAL HOUSING

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MARYLAND

13b COUNTY

MONTGOMERY

13c CITY OR TOWN

ROCKVILLE

13d INSIDE CITY LIMITS?

YES ☐ NO ☐

13e STREET ADDRESS / ZIP CODE

13137 BEAVER TERRACE 20853

14 FATHER'S NAME

FIRST

FLOYD

MIDDLE

WALTER

LAST

TREMELL, SR.

15. MOTHER'S MAIDEN NAME

FIRST

EVELYN

MIDDLE

LAST

GOROUM

16a WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

218-38-5277

17. INFORMANT ADDRESS

VALERIE A. TRAMMELL/WIFE SAME AS 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Brain death

DUE TO, OR AS A CONSEQUENCE OF

(b)

Ventricular artery occlusion

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days

2 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

YES ☒ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☒ NO ☐21a ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐

AT WORK AT WORK

21e PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (this hospital) attended the deceased from 2-16-19-87 to 8-18-19-87 that (I) (we) last saw the deceased alive on 8-18-19-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

Octavio Polanco

DEGREE

MD

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c DATE SIGNED

8/19/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)

OCTAVIO POLANCO

22e ADDRESS

5530 WISCONSIN AVE #820 CHEVY CHASE, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b DATE

AUG 21, 1987

23c NAME OF CEMETERY OR CREMATORY

PARKLAWN

23d LOCATION

CITY OR TOWN

COUNTY

STATE

ROCKVILLE MONTGOMERY MARYLAND

24 FUNERAL DIRECTOR

NAME

FRANCIS J. COLLINS, JR.

ADDRESS

500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901

25 DATE RECD BY REGISTRAR

AUG 24 1987

25 REGISTRAR'S SIGNATURE

James D. Smith-Randall

083013 010201

083013 010201

61938 AUG -7 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24062

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth M Tremblay		2a. DATE OF DEATH MONTH 8 DAY 3 YEAR 87		2b. HOUR 8:45 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 18	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERICAL WORK		12b. KIND OF BUSINESS OR INDUSTRY JOHN DEERE, INC			
13a. STATE MD		13b. COUNTY PR GEO		13c. CITY OR TOWN HYATTSVILLE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6904 25th AVENUE 20783			
14. FATHER'S NAME FIRST GEORGE MIDDLE SEAFER LAST SEAFER		15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE PEWE LAST PEWE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 331-09-0658		17. INFORMANT ADDRESS GERALD F. REEVES 6904 25th AVE HYATTS MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Card failure (c) Sepsis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pseudo Membranous Enterocolitis w/fulminant Decubitus, Multiple Sclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I or Part 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 731 87 813 87	
22a. I certify that (I) (this hospital) attended the deceased from 8-2 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE MEHDI P. FARZIN MD		DEGREE MD		22c. DATE SIGNED 8-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MEHDI P. FARZIN		22e. ADDRESS 7525 Greenway CTR dr. Greenbelt Md.			
23a. BURIAL, CREMATION, REMOVAL 15b. BURIAL		23b. DATE AUG. 7, 1987		23c. NAME OF CEMETERY OR CREMATORY ROCK ISLAND NATIONAL CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE Rock Island ILLINOIS		23e. DATE REC'D BY REGISTRAR AUG 5 1987		23f. REGISTRAR'S SIGNATURE Julia S. R. Rude	
24. FUNERAL DIRECTOR NAME John J. Farz		24b. ADDRESS 4545 Calver Rd. Wash D.C. 20012			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. They please remove carbon papers (Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene, Bureau of Vital Records, Baltimore, Maryland).

IMPORTANT: If item 21 is marked on item 18, it shows only injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Dear" and "Yours" are faintly visible.]

064440 SEP-1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH4063
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Kurt Turner			2a. DATE KNOWN OF DEATH ESTIMATED 8-24-1987			2b. HOUR 9:30 P.M.		
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 4 10 63	6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD 8-24-1987		
7a. BIRTHPLACE (STATE OR COUNTRY) Connecticut.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY Automotive	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GATHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 111 TULIP DRIVE/20877
14. FATHER'S NAME FIRST MIDDLE LAST John W. Turner, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arline E. Linke			16. ADDRESS 95 Ocean Blvd.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 92 9505		17. INFORMANT John W. Turner, Jr. Kitty Hawk, N.C. 27946				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE ORGAN FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) MULTIPLE TRAUMA DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 9 DAYS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.								
19a. DATE OF OPERATION 8/18/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? INCREASED INTRACRANIAL PRESSURE				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 14 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) HIT CAR WITH MOTORCYCLE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Montgomery Village Ave & Choptank Road, Bethesda, Maryland			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Francis C. Mayo Jr.			TITLE (SPECIFY) SEPT			DATE SIGNED 8/25/87		
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayo Jr.			ADDRESS 8200 Wisconsin Ave Bethesda, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE August 27, 1987		23c. NAME OF CEMETERY OR CREMATORY Montgomery Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda Maryland	
24. FUNERAL DIRECTOR Robert A. Humphrey Funeral Home, Bethesda-Chevy Chase, Inc.					25. DATE REC'D. BY REGISTRAR AUG 31 1987			
26. ADDRESS 7557 Wisconsin Ave, Bethesda, Maryland					27. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

04440 29-1 81



AUG 31 1981

064579 SEP-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

4064

1- FOR
STATE REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MOSHE

TUR-ZIN

2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
8-23 1987
2b. HOUR 1:40 P M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

8-30-45

6. AGE (IN YEARS)

41 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8-23 1987
2d. HOUR 1:40 P M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

POLAND

7b. CITIZEN OF WHAT COUNTRY?

ISRAEL

8. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY MD

10. CITY OR TOWN OF DEATH

Bethesda

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

ENGINEER

12b. KIND OF BUSINESS OR INDUSTRY

INDUSTRIAL

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

ISRAEL

13b. COUNTY

KIRYAT-HAIM

13c. CITY OR TOWN

KIRYAT-HAIM

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

9 BEN ZVI STREET

14. FATHER'S NAME

MANAHEN

MIDDLE

MEDEL

14. FATHER'S NAME

TUR-ZIN

15. MOTHER'S MAIDEN NAME

HINIA

MIDDLE

TUCHMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

16b. SOCIAL SECURITY NO.

none

17. INFORMANT

MALKA TUR-ZIN, 9 BEN ZVI STREET, KIRYAT-HAIM, ISRAEL

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

Cardio Respiratory Arrest

(b) Coronary arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐

AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion

death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John Tauber

TITLE (SPECIFY)

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

8-23-87

EXAMINER'S NAME

(TYPE OR PRINT)

John Tauber

ADDRESS

8218 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL

REMOVAL

23b. DATE

8/24/1987

23c. NAME OF CEMETERY OR CREMATORY

MAALIN BAKODESH SOCIETY

23d. LOCATION

BROOKLYN

COUNTY NEW YORK

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME

25a. DATE REC'D BY REGISTRAR

AUG 28 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Randall

232 CARROLL STREET, N. W., WASHINGTON, D. C.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED FOR A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

999999

(VR A15 ME (5))

004210 20-501

141

REPT. MOTOD. 200



100 3 8 101

064663 SEP-387

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24065

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (PRINT) FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
LYLE F URBAN		08 27 87		1943 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	C	MONTH DAY YEAR	73 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
S.D.A.K.	USA		Montgomery County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park	Washington Adventist Hosp		REAL ESTATE APPRAISER		H.U.D.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	PR GEORGES	ADELPHI	YES <input type="checkbox"/> NO <input type="checkbox"/>	2502 KILLDEER AVENUE 20783	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
FRANK URBAN		LIBBIE VESELY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		504-03-5104		L. EVALENA URBAN/WIFE SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Maligned cardiac arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Base Surge secondary artery disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (If any) <u>SIP Aortic valve pathology for aortic stenosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/27/87</u> 19 <u>87</u> , to <u>8/27/87</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/27/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>S. Collins</u>					
22d. PHYSICIAN'S NAME (PRINT OR PRINT)		22e. ADDRESS			
<u>S. Collins</u>		<u>PO BOX 1072 Church</u>		<u>MD 20788</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		AUG 31, 1987		NATL MEM PARK CEMETERY FALLS CHURCH	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS, JR.		SEP 02 1987		<u>John Collins</u>	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901					

DHMH - 16 60M 7/84
(VRA 15, 4)

BP _____

084803 SEP-381

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Handwritten notes, possibly a list or description of items, including phrases like "small box", "large box", and "medium box".

SEP 03 1938

064241

AUG 31 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 17 shows any injury, or after a traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24065

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Tip Y. Van Brunt			2a. DATE OF DEATH MONTH DAY YEAR Aug. 22, 1987		2b. HOUR 3 AM														
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.													
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3706 Cardiff Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home											
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3706 Cardiff Road/20815											
14. FATHER'S NAME FIRST MIDDLE LAST David F. Youngblood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cannie --- Stroud				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-46-2199				17. INFORMANT ADDRESS Rinalda Stevens, RD4, Apple Tree La, Bethlehem, PA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UNKNOWN DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours 4 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive heart failure																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from JUL 19 85 to 11 AUG 19 87, that (I) (we) last saw the deceased alive on 11 AUG 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Jerome S. Herbers MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 25 AUG 87											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEROME E HERBERS JR.				22e. ADDRESS Walter Reed Army Medical Center Washington DC															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/87		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA													
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.				ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE RECEIVED BY REGISTRAR AUG 28 1987											

MEDICAL CERTIFICATION

004541 1 AUG 31 05

ON

4

062887 AUG 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page, and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24067
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WILLIAM GARRETT VAN METER JR.				AUGUST 9, 1987		5:15 A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE	MAY 1, 1966		21 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	NIH, THE CLINICAL CENTER			Student		Loyola Col Baltimore	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		Montgomery	ROCKVILLE			4605 JASMINE DRIVE 20853	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
William Garrett Van Meter, Sr.			Bonnie Jean Duffy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		218-92-1823		WILLIAM VAN METER, SR. (Same) as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) REFRACTORY LYMPHOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAY 11, 1987, to AUGUST 9, 1987, that (X) (we) last saw the deceased alive on AUGUST 9, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8/9/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Hansen		NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8/12/87		Gate of Heaven Cemetery		Silver Spring, Maryland	
24. FUNERAL DIRECTOR'S NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				AUG 14 1987		Julia Davidson-Randall	

BP

065887 AUG 17 81

1

AUG 14 1981

064681 SEP -3 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24068
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Lou LAST Vaughan			2a. DATE OF DEATH MONTH DAY YEAR 8 28 87		2b. HOUR 12 ⁰³ PM						
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 16 26		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH GREENBELT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON TOWN DAY ADVENT.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8936 CARROLL Hgts. 20794		
14. FATHER'S NAME FIRST ARTY MIDDLE BARBER LAST						15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE Richardson LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS CHART					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immunization</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic outcall lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Tumor</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Leukopenia & Thrombocytopenia</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>22 Jan 87</u> to <u>28 Aug 87</u> , that (I) (we) last saw the deceased alive on <u>28 Aug 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or was (did) not see the body after death).											
22b. SIGNATURE <u>Thomas A. Bensinger</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER						22e. ADDRESS 7025 GREENWAY CIR Dr. Greenbelt MD 20770					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-2-87		23c. NAME OF CEMETERY OR CREMATORY ARBUS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR NAME E.L. Phillips						ADDRESS 1721 27N. MONROE Street		25a. DATE REC'D. BY REGISTRAR SEP 2 1987		25b. REGISTRAR'S SIGNATURE John Andrew Phillips	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.)

BP

Received of [illegible] the sum of [illegible]
 for [illegible] [illegible] [illegible]
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62176 AUG 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24069
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIANO CONCEPCION VELARDE			2a. DATE OF DEATH MONTH DAY YEAR August 1, 1987			2b. HOUR 5:20 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 8, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 24	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peru		7b. CITIZEN OF WHAT COUNTRY? Peru		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE SANTIAGO-SURCO, PERU				13b. CITY OR TOWN PERU		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE Giron Tacna #159 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Genaro Velarde				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Concepcion Villamonta					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Celia de Velarde, Same as Line #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hepatic Failure DUE TO, OR AS A CONSEQUENCE OF (b) Post Necrotic Cirrhosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from July 21, 1987 , to August 1, 1987 , that (I) (we) last saw the deceased alive on August 1, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Allen A. Nimetz MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED 8/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen A. Nimetz				22e. ADDRESS 5401 Western Ave. N.W. Wash, DC.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 6, 1987		23c. NAME OF CEMETERY OR CREMATORY El Angel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lima, Peru			
24. FUNERAL HOME NAME ADDRESS FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

065178 AUG 10 85

062486 AUG 13 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24070
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Velisar		2a. DATE OF DEATH MONTH DAY YEAR August 8, 1987		2b. HOUR 12:15 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b. CITIZEN OF WHAT COUNTRY? Greece	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY At home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Anthony Papastathopoulos		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marigoula Drakopoulos		13e. STREET ADDRESS / ZIP CODE 1235 Potomac Valley Road 20850	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-52-2132		17. INFORMANT ADDRESS George Lalos 10510 Streamview Ct. Potomac, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/30 19 87 , to 8/8 19 87 , that (I) (we) lost saw the deceased alive on 8/8/87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Deborah B Goldberg		DEGREE MD		22c. DATE SIGNED 8/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Deborah B Goldberg		22e. ADDRESS 1106 Spring St, Silver Spring Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-10-87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr. George, Md.		25a. DATE REC'D. BY REGISTRAR AUG 12 1987			
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons 5130 Wisc. Ave. N.W.		25b. REGISTRAR'S SIGNATURE John D. ...			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

062186 AUG 13 67

No 578-52-2132 George James 10510 Streamview Ct. Potomac, Md.
 Anthony Papastathopoulos Maryland
 Montgomery Rockville x 1535 Potomac Valley Road
 Silver Spring Holy Cross Hospital Homeowner At home
 Grace G.W.A.A. x Montgomery County
 White May 15, 1960 97
 Voltaire August 8, 1967 12:15 PM

Joseph Hawley's home 1150 Mac. Ave. N.E.
 6-10-67 Mt. Lincoln Cemetery Brentwood, D.C.
 1150 Mac. Ave. N.E.

064246 AUG 31 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B allows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 24071

1. DECEASED NAME (TYPE OR PRINT) Baby Boy (RODWICK) Vickerie			2a. DATE OF DEATH MONTH DAY YEAR 8-19-87			2b. HOUR 0548 A M					
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8-18-87		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS.		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 7 02	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE md				13b. COUNTY Prince Georges		13c. CITY OR TOWN Hyattsville		13d. STREET ADDRESS / ZIP CODE 6418 Kilmer Street 20785			
14. FATHER'S NAME FIRST MIDDLE LAST MONTY T. VICKERIE				15. MOTHER'S MAIDEN NAME Elva Arokium							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Monty T. Vickerie (father) same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) Extreme Immaturity										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION /			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED /			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 18 19 87, to Aug 19 19 87, that (I) (we) lost saw the deceased alive on Aug 19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE m chon m d.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) margaret m. chon						22e. ADDRESS Holy Cross Hospital - Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE John S. ...			

BP

064548 AUG 31 05

AUG 30 1965

065225 SEP 10 1987
Retyped to
Correct time
of death

Items 2ed, 25a, Film G634 12-1-87 dw		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		24072 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eve M. Visco			2a. DATE OF DEATH MONTH DAY YEAR August 04, 1987		2b. HOUR 5:54 p.m.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 05, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 1 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 266-38-4073	17. INFORMANT EUGENE VISCO ADDRESS 3752 Capulet 20906		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure/Pulmonary Edema years DUE TO, OR AS A CONSEQUENCE OF (c) Cardiogenic Shock/Acute MI Approximate interval between onset and death: hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: COPD					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/4/87 19 87 to 8/4 19 87 , that (I) (we) last saw the deceased alive on 8/4 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alan Spealman				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan Spealman				22e. ADDRESS Montgomery General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Norbeck Memorial Park Olney, Md	
24. FUNERAL DIRECTOR NAME Robert Pumphrey		ADDRESS 300 W. Montgomery		25a. DATE REC'D. BY REGISTRAR SEP 08 1987	
				25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

done today 5:40p. 10/10/81

064106 AUG 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24073
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ella Lloyd Vitol			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1987		2b. HOUR 8:35P M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 15, 1903		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15003 Westholm Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own Home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Lloyd		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Heck		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16b. SOCIAL SECURITY NO. 578 60 7881		17. INFORMANT ADDRESS 20850 James L. Vitol, 11 Wall St., Rockville, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Atrial Arrhythmia organic Brain Syndrome							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/12, 1984, to 8/23/87, 19, that (I) XX last saw the deceased alive on 8/19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) XX (did not) view the body after death.							
22b. SIGNATURE Douglas R. Shumaker M				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 24, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas R. Shumaker, M.D.				22e. ADDRESS 615 W. Montgomery Av., Rockville, Md. 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 26, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Ave. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies of pages 1 and 2 and submit them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic cause of death, and the medical examiner must be notified at once.

BP

0 6 4 1 0 8 AUG 58 87

64450 SEP-1

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24074
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARISSA L VOLZ		2a. DATE OF DEATH MONTH DAY YEAR 08 24 87		2b. HOUR 10¹⁰ PM	
3. SEX Female	4. RACE Car	5. DATE OF BIRTH MONTH DAY YEAR 8 10 - 02		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	

13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST CHRISTOPHER FASSOLD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARISSA HOBBS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577-34-7452		17. INFORMANT SON ADDRESS 9458 WOODEN GLEN AVE. BURKE, VA 22015	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe Coronary Artery Disease					
19a. DATE OF OPERATION 8/24/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured Hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from August 23, 1987 to August 24, 1987 , and that (2) (we) lost sight of the deceased and alive on August 24, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE Mark H. G.S.				22c. DATE SIGNED 8/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark H. G.S.				22e. ADDRESS 9801 Geodora Ave Silver Spring, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 27, 1987		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEM PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VA		24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901			
25a. DATE REC'D. BY REGISTRAR AUG 31 1987				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

04420 SEP-187

08 20 10/1

10/1

04420

Point Lighthouse

Seaside Cemetery

10/1

X

10/1

10/1

10/1

10/1

64445 SEP -1 87

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24075

1. DECEASED NAME (TYPE OR PRINT) Catherine Fortune Vuozzo			2a. DATE OF DEATH MONTH DAY YEAR Aug 22 87			2b. HOUR 21:55M				
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Aug 28 1929		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn NY		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4102 ELBY STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager		12b. KIND OF BUSINESS OR INDUSTRY RETAIL		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4102 Elby St 20906	
14. FATHER'S NAME FIRST MIDDLE LAST George Steven Fortune			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget McNamara			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 106-22-1305	
17. INFORMANT DAUGHTER			ADDRESS 17124 CHISWELL RD POOLESVILLE, MD 20837			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b). Widespread metastatic Sarcoma DUE TO, OR AS A CONSEQUENCE OF (c).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 None										
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A				
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 7/25/87 to 8/22/87										
22b. SIGNATURE John E. McKnight			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. McKnight MD			22e. ADDRESS 2121 Pa Ave NW							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE AUG 26, 1987		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.			24b. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25a. DATE REC'D. BY REGISTRAR AUG 31 1987				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the death certificate must be signed by the medical examiner.

BP

04442 SEP-107

RECEIVED
SEP 10 1947

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064763 SEP-4 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24076
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hattie			FIRST MIDDLE LAST WAGNER			2a. DATE OF DEATH MONTH DAY YEAR 8-31-87			2b. HOUR 945 AM		
3 SEX FEMALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 1 8 1895			6. AGE (IN YEARS LAST BIRTHDAY) 92		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Buyer (Retired)			12b. KIND OF BUSINESS OR INDUSTRY Hecht Company		
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Olney			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Nusbaum			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Goodman			13e. STREET ADDRESS / ZIP CODE 18430 Brooke Grove Rd. (20832)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-3295			17. INFORMANT Dr. Sidney R. Nusbaum; Nephew;			ADDRESS Trenton, N.J. 08628		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ESOPHAGEAL DYSMOTILITY LEADING TO CACHEXIA											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from December 19 86 , to August 19 87 that (I) (we) last saw the deceased alive on August 21 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE T. E. Howe MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-31-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TED E. HOWE MD			22e. ADDRESS OLNEY, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/1/87			23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden			23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church; Fairfax; Va.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR SEP 3 1987			25b. REGISTRAR'S SIGNATURE J. J. ...		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

004783 SEP-48

5. *Other*

062886 AUG 17 87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24077
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Laura Estell Walker			2a. DATE OF DEATH MONTH DAY YEAR August 8, 1987		2b. HOUR 9:00 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 12, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4521 Sangamore Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Edward			15. MOTHER'S MAIDEN NAME Susan nm Schrider		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-7362A	17. INFORMANT Germantown, Maryland 20874 Thomas Walker (son) 13428 Tilford Ct.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years 4 years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/13/87, 19 87, to 6/16/87, 19 87, that (I) (we) last saw the deceased alive on 6/15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Emmer		DEGREE MD		22c. DATE SIGNED 8/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Emmer		22e. ADDRESS 6316 Democracy Blvd. Bethesda, Md. 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/13/87	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Henderson	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

06588 AUG 17 84

1681
062357 AUG 11 1987
FOR STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24078
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Albert WARTHEN			2a. DATE OF DEATH MONTH DAY YEAR August 6, 1987		2b. HOUR 10:36 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 21, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	12b. KIND OF BUSINESS OR INDUSTRY Appliances	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gurney Warthen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie C. Leach		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	17. INFORMANT Mary L. Warthen,		Item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, myocardial infarction 4 years DUE TO, OR AS A CONSEQUENCE OF (b) Aortic stenosis DUE TO, OR AS A CONSEQUENCE OF (c) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/18 19 65 to 8/6 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive <input checked="" type="checkbox"/> above, (I) <input checked="" type="checkbox"/> did not <input type="checkbox"/> saw the body after death, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE James P. Kerr, M.D.		DEGREE		22c. DATE SIGNED 8/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr, M.D.		22e. ADDRESS 26618 Ridge Rd., Damascus, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 8, 1987	23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.		25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE Julia Bender-Randall	

Medical Examiner
cleared by Dr. John S. Rogers, Medical Examiner

BP

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IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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063390 AUG 21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24079
REG. NO.

+ 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BPDHMH - 16 60M 7/84
(VRA 15, 4)

1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST E L O M B. WASHINGTON II		2a. DATE OF DEATH MONTH DAY YEAR 8 7 87		2b. HOUR 1:43 PM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 8 4 60		6. AGE (IN YEARS LAST BIRTHDAY) 27	
7a. BIRTHPLACE (STATE OR FOREIGN) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (GIVE WORK OR MOST OF WORKING LIFE) Labor Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STREET DC		13b. COUNTY DC		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST E L O M B. WASHINGTON II		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHRISTINE FREE MAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 225 04 4271	
17. INFORMANT ADDRESS 3009 Red Lion		17. NAME CHRISTINE WASHINGTON		17. ADDRESS SILVER SP. MD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Cryptococcal Meningitis Acquired Immunodeficiency Syndrome		2 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 Recent Pneumocystis Pneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8-3, 19 87, to 8-7, 19 87, that (I) (the hospital) saw the deceased alive on 8-7, 19 87, and that in (my) (the hospital's) opinion death occurred on the date and hour and from the causes stated above, (I) (the hospital) (did not) view the body after death.							
22b. SIGNATURE Barbara R. Shoback		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-8-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara R Shoback		22e. ADDRESS 1011 N. Capitol St. Wash DC					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/13/87		23c. NAME OF CEMETERY OR CREMATORY HARMONY PARK		23d. LOCATION CITY OR TOWN COUNTY STATE HANDOVER APT, MD	
24. FUNERAL DIRECTOR NAME R.N. HOATON & CO. MONT.		ADDRESS 600 KENNEDY ST		25a. DATE REC'D. BY REGISTRAR AUG 18 1987		25b. REGISTRAR'S SIGNATURE Asia Davidson-Randall	

063330 JUN 21 63

U.S. AIR FORCE
HEADQUARTERS
10000th Ave

TO: DIRECTOR, AIR FORCE
FROM: [illegible]
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

11. [illegible]
12. [illegible]
13. [illegible]
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17. [illegible]
18. [illegible]
19. [illegible]
20. [illegible]

21. [illegible]
22. [illegible]
23. [illegible]
24. [illegible]
25. [illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24080
REG. NO.

1. FOR
STATE
REGISTRAR

061936 AUG - 7 87

1. DECEASED NAME (Type or Print) FIRST MIDDLE LAST GERSON LOUIS WEINSTEIN			2a. DATE OF DEATH MONTH DAY YEAR August 3, 1987			2b. HOUR 8 a. m.	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR August 28, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10703 Cavalier Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production Planner; U.S. Gov't.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10703 Cavalier Drive (20901)	
14. FATHER'S NAME FIRST MIDDLE LAST George Saul Weinstein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Woolf							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Silver Spring, Md. Frances F. Weinstein; Wife; 10307 Cavalier Dr.;					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>bleeding effusion</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) <u>one minute Convulsion</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>25414</u> , 19 <u>87</u> , to <u>8-2-1987</u> , that (I) (we) last saw the deceased alive on <u>8-2-1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Robert Kramer M.D.</u> DEGREE						22c. DATE SIGNED Aug. 3, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER, M.D.						22e. ADDRESS 10313 Georgia Avenue, Suite 209; Silver Spring Md. 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/87		23c. NAME OF CEMETERY OR CREMATORY Sharon Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sharon, Massachusetts	
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR AUG 5 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene after 24 hours after death. Page 3 should be destroyed for use as the burial-transit permit. Then these remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 is checked, the medical examiner or other authorized official must be notified of this.

061836 AUG-2-81

3

063302 AUG 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2408
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA MILDRED WELCH			2a. DATE OF DEATH MONTH DAY YEAR August 15, 1987		2b. HOUR 10:40		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Vienna		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 508 Cottage Street, S.W.		13f. ZIP CODE 22180		14. FATHER'S NAME (FIRST MIDDLE LAST) (UNAVAILABLE) Morris		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) (UNAVAILABLE)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-30-8131		17. INFORMANT ADDRESS Thomas H. Welch, Same as Line #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart DUE TO, OR AS A CONSEQUENCE OF (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Septicemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-20 , 19 87 , to 8-15 , 19 87 , that (I) (we) saw the deceased alive on 8-15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Tauber		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS 8218 Wisconsin Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08-18-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland	
24. FUNERAL HOME OR ADDRESS FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				DATE REC'D. BY REGISTRAR AUG 19 1987		REGISTRAR'S SIGNATURE Julia Gordon-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1387
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH24082
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF ESTI- MATED			2c. DATE PRONOUNCED DEAD		
SIDNEY			WELLS			08 02 1987			11 42		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		
M	CAUC	04 05 12	75 YRS.			VA.			USA		
7c. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
ROCKVILLE			SHADY GROVE ADVENTIST HOSPITAL			WIDOWED			MONTGOMERY		
12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. COUNTY			13b. CITY OR TOWN			13c. STREET ADDRESS		
MD			MONTGOMERY			POOLESVILLE			17705 ELGIN RD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
SIDNEY			Blanche Shank			YES			399-09-8097		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			17. INFORMANT			ADDRESS		
PART I DEATH WAS CAUSED BY:			ACUTE			Hoxe			Blanche Shank		
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES			NO		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED					
			P.M. 08 02 1987			COLLAPSED AT HOME					
21d. INJURY OCCURRED WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
NOT WHILE AT WORK			HOMEYARD			17705 ELGIN RD POOLESVILLE MONT MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Francis C. Mayle			M.D. DEPT			8/02/87					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
Francis C. Mayle			22011 Backville Rd. Bethesda Md.			CREMATION			AUG 11 1987		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
William Hiltow			AUG 11 1987			Julia Tindall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24083
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irene B. Wendler			2a. DATE OF DEATH MONTH DAY YEAR August 17, 1987		2b. HOUR 11:00pm
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 25, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales	12b. KIND OF BUSINESS OR INDUSTRY Retail	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 199 Rollins Avenue/20852	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Mann		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Unavailable			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 182 03 3862	17. INFORMANT (Daughter) ADDRESS Dorothy W. Davis 5910 Walton Rd. Bethesda, Md. 20817		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-respiratory failure (c) Generalized Arteriosclerosis					5 years 20 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Post CVA- left brain plegia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 21, 1975, to August 17, 1987, that (I) (we) last saw the deceased alive on August 11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John Wyman</i>				22c. DATE SIGNED August 18, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Wyman M.D.				22e. ADDRESS 7801 Norfolk Avenue Bethesda, Maryland 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE August 21, 1987	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ 300 West Montgomery Avenue Rockville, Maryland				25a. DATE RECEIVED BY REGISTRAR AUG 20 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HP
DHMH - 16 60M 7/84
(VP 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24084
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HELEN YOUNG WHEATLEY			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 8 1987			2b. HOUR P M 9:00 P M				
3 SEX FEMALE		4 RACE ORIENTAL		5. DATE OF BIRTH MONTH DAY YEAR JUNE 6 1921		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA			13b. COUNTY FAIRFAX		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 118 E. TAYLOR RUN PARKWAY 22314	
14. FATHER'S NAME FIRST MIDDLE LAST HWA CHEN WENG			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL CHENG							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-88-7433		17. INFORMANT ADDRESS NORRIS N. WHEATLEY, 118 EAST TAYLOR RUN PARKWAY					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF UNKNOWN PRIMARY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JULY 16 , 19 87 , to AUGUST 8 , 19 87 , that (I) (we) last saw the deceased alive on AUGUST 8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 				DEGREE MD				22c. DATE SIGNED 10 AUG 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. A. DOWGIN, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-12-87		23c. NAME OF CEMETERY OR CREMATORY Maryland National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland				
24 FUNERAL DIRECTOR NAME Everly-Wheatley Funeral Home				25a. DATE REC'D. BY REG. CLERK AUG 14 1987		25b. REGISTERED 				
1500 W. Breddock Rd. Alexandria, VA										

MEDICAL CERTIFICATION

003002 AUG 19 91

2000 COLLECTIBLES

NEW YORK

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63643 AUG 25 1987

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24085
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CONSTANCE SHELTMAN WHITE			2. DATE OF DEATH MONTH DAY YEAR 8-17-87			3. HOUR 915 P.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11 19 1891		6. AGE (IN YEARS LAST BIRTHDAY) 95		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALTHEA WOODLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN MCLEAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WADE SHELTMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE CONSTANCE		16. 1251 OLD DOMINION DR. 22101 Carl Vinson Hall			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 401-12-977		17. INFORMANT ADDRESS LILY GRIDLEY/1200 FIRTH OF LORNE, FT. WASHINGTON, MD			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **1-9-1987**, to **8-17-1987**, that (I) (we) last saw the deceased alive on **8-17-1987**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Bruce S. Rashbaum MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE S. RASHBAUM				22e. ADDRESS 217 University Blvd. Silver Spring, Md 20901			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8/20/87		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, DC	
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24. FUNERAL DIRECTOR MURPHY FUNERAL HOME/4510 WILSON BLVD. ARLINGTON, VA				25a. DATE REC'D BY REGISTRAR AUG 24 1987				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use in the funeral transit permit. Then please remove it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, or medical examiner must be notified and signed.

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064828 SEP-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24086
REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST Maude	MIDDLE L.	LAST White	2a. DATE OF DEATH MONTH DAY YEAR August 28, 1987	2b. HOUR 10:25 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 103 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Carriage Hill Silver Spring			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9412 Woodland Dr./20910
14. FATHER'S NAME FIRST MIDDLE LAST Jacob --- Browne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Jane Maphis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-46-7821		17. INFORMANT ADDRESS 5616 Knollwood Rd. Virginia C. Thompson, Bethesda, MD 20816				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>advanced age</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9-17-1965</u> to <u>8-28-1987</u> . That (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>8-27-1987</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <u>George F. Songstack, M.D.</u>						22c. DATE SIGNED Aug. 28, 1987		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George F. Songstack, M.D.						22e. ADDRESS 3929 Ferrara Dr., Silver Spring, MD 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/1/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE SEP 04 1987 <u>J. A. Davidson</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 31, shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

064828 SEP-88

10:00 AM August 28, 1987 White Large

Montgomery

Garrison Hill Silver Spring

Silver Spring

4-12-88 (10:00 AM)

Montgomery Silver Spring

Montgomery

Montgomery

Montgomery

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Montgomery

Montgomery, Silver Spring, MD

Montgomery, Silver Spring, MD

Montgomery

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Aug. 28, 1987

3000 Terrace Dr., Silver Spring, MD 20905

George F. Bonetack, N.D.

SEP 04 1987

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial permit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE C. LAST WHITING WILLIAM C. WHITING					2a. DATE OF DEATH MONTH DAY YEAR 8-31-87					2b. HOUR 11 am	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 2, 1908 MONTH DAY YEAR 10 12 08		6. AGE (IN YEARS LAST BIRTHDAY) 78.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D. e.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHARON NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. BUSINESS OR INDUSTRY PRINTING OFF.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY MONT.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ZIP CODE 4949 BATTERY LANE 20814		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE WHITING					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE E. GLOFF						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 216-44-8841A		17. INFORMANT ADDRESS Myrtle A. Whiting Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bradycardia induced and</u> DUE TO, OR AS A CONSEQUENCE OF <u>Chronic CV Dse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Bradycardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>First time severe left S. A. block</u>										18b. INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <u>First time severe left S. A. block</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28/87</u> to <u>8/31/87</u> that (I) [we] last saw the deceased alive on <u>8/28/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C. H. Hagan</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/3/87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. H. Hagan</u>					22e. ADDRESS <u>1811 Pr Philip Dr Olney Md 20832</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE SEPT. 3, 1987		23c. NAME OF CEMETERY OR CREMATORY JENNINGS CHAPEL		23d. LOCATION JENNINGS CHAPEL HOWARD STATE MD.				
24. FUNERAL DIRECTOR NAME MURIEL H. BARBER LAYTONSVILLE, MD. 20879					25a. DATE REC'D. BY REGISTRAR SEP 4 1987		25b. REGISTRAR'S SIGNATURE <u>Mia Gordon-Rubell</u>				

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[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side. Some words like "RECEIVED" and "SEP 1981" are faintly visible.]

064830 SEP-87

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24088
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Johanne		MIDDLE	LAST Wickstrom	2a. DATE OF DEATH MONTH DAY YEAR August 28, 1987		2b. HOUR 1:30pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 27, 1945		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13113 Chestnut Oak Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13113 Chestnut Oak Drive 20878	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Dion				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angie Slaughter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 373 46 4986		17. INFORMANT David L. Wickstrom (husband) 20878 13113 Chestnut Oak Dr. Gaithersburg Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 mos</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 8, 1985</u> to <u>Aug 28, 1987</u> , that (I) (we) last saw the deceased alive on <u>June 8, 1987</u> ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frederick P. Smith</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick P. Smith				22e. ADDRESS 5401 Western Ave. N.W. Wash. DC 20015					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/87		23c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		23d. LOCATION Darnestown, Maryland			
24. FUNERAL DIRECTOR NAME Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR SEP 04 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked "b", item 21a shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

Printed on acid-free paper.

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062521 AUG

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by entry.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2. DECEASED NAME (PRINT) SANFORD		3. FIRST MIDDLE SANFORD		4. LAST WIESENTHAL		5. DATE OF DEATH 8 7 87		6. TIME 9:30 PM	
7. SEX MALE		8. RACE WHITE		9. DATE OF BIRTH 11 4 32		10. AGE (IN YEARS LAST BIRTHDAY) 54		11. IF UNDER 1 YEAR MONTHS 8 DAYS 7		12. IF UNDER 24 HRS. HOURS 9 MIN 30	
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		14. CITIZEN OF WHAT COUNTRY? USA		15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		16. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO.		17. MD.			
18. CITY OR TOWN OF DEATH SILVER SPRING		19. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 308 IRWIN ST.		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		21. KIND OF BUSINESS OR INDUSTRY WASH. GAS CO.					
22. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING		23. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24. STREET ADDRESS / ZIP CODE 308 IRWIN STREET #20901							
25. FATHER'S NAME FIRST ABRAHAM MIDDLE WIESENTHAL LAST WIESENTHAL		26. MOTHER'S MAIDEN NAME FIRST SADIE MIDDLE BERKOWITZ		27. MRS. HARRIET WIESENTHAL							
28. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		29. SOCIAL SECURITY NO. 297-26-7012		30. INFORMANT MRS. HARRIET WIESENTHAL		31. ADDRESS 308 IRWIN ST., SILVER SPRING., MD 20901					
32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
33. DATE OF OPERATION		34. CONDITION FOR WHICH OPERATION WAS PERFORMED				35. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		36. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
37. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		38. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 87		39. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
40. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		41. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		42. LOCATION STREET CITY OR TOWN COUNTY STATE							
43. I certify that (I) (this hospital) attended the deceased from 8/7 19 87 to 8/7 19 87 , that (I) (we) last saw the deceased alive on 8/7 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
44. SIGNATURE Mark F. Weinstein MD				45. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				46. DATE SIGNED			
47. PHYSICIAN'S NAME (TYPE OR PRINT) MARK F. WEINSTEIN MD				48. ADDRESS 1125 ROCKWILLE AVE, ROCKWILL MD							
49. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		50. DATE 8-9-87		51. NAME OF CEMETERY OR CREMATORY ARLINGTON-CHIZUK AMUNO		52. LOCATION CITY OR TOWN BALTIMORE COUNTY STATE MD					
53. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215						54. DATE REC'D. BY REGISTRAR AUG 12 1987		55. REGISTRAR'S SIGNATURE Julia Gordon-Rodgers			

005251 AUG 13 64

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24090
REG. NO.

1. DECEASED NAME (Type or print) Marvin L. Wilkerson			2a. DATE OF DEATH MONTH DAY YEAR 08 07 87			2b. HOUR 2130 M.	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 08 16 34		6. AGE (IN YEARS LAST BIRTHDAY) 33	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. Washington		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Takoma Park, Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Heights District		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Marion J. Wilkerson Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Creek		13e. STREET ADDRESS / ZIP CODE 2097 Addison Road 20747			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 215-64-4050		17. INFORMANT ADDRESS Odell Wilkerson District Heights, Md. 20747			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Infiltrat DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Prostateitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 18 Feb 87 to 7 Aug 87 , that (1) (we) last saw the deceased alive on 7 Aug 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE Thomas A. Bensinger		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER		22e. ADDRESS 7525 Greenway Ctr Drive Greenbelt MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/87		23c. NAME OF CEMETERY OR REPOSITORY Union M Church		23d. LOCATION CITY OR TOWN COUNTY STATE Tracy's A.A. 20770	
24. FUNERAL DIRECTOR NAME Leroy E. Berry		ADDRESS Huntingtown, Md. 20639		25a. DATE REC'D. BY REGISTRAR AUG 11 1987			

002422 AUG 15 81

Handwritten notes and stamps, including "002422 AUG 15 81" and "002422 AUG 15 81".

063534

AUG 24 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24091

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clingman L. Williams			2a. DATE OF DEATH MONTH DAY YEAR 8 13 87			2b. HOUR 12²⁵ PM				
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 16 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montg. MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grosvenor Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. STATE D.C.		13b. COUNTY Wash.		13c. CITY OR TOWN Wash.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 829 Crittenden St. N.W.		
14. FATHER'S NAME FIRST MIDDLE LAST Louis W. Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lusille Hodges			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 578-18-2164			17. INFORMANT Mildred C. Williams			ADDRESS 829 Crittenden St. N.W.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Septicemia DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-1 , 19 87 , to 8-13 , 19 87 , that (I) (we) last saw the deceased alive on 8-13 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John Tauber			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber			22e. ADDRESS 8218 Wisconsin Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-17-87		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Johnson & Jenkins			ADDRESS 716 Kennedy St. NW			25a. DATE REC'D. BY REGISTRAR AUG 21 1987			25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84
(VRA 15, 4)

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1064564 SEP-28

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 4 0 9 2

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (OR PRINT) Robert Edward Williams			2a. DATE KNOWN OF DEATH ESTIMATED Aug 14 1987			2b. HOUR 7		
3. SEX M	4. RACE Blk	5. DATE OF BIRTH MONTH DAY YEAR Aug 16 1920 67	6. AGE (IN YEARS) (LAST BIRTHDAY) 67 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Aug 14 1987	2d. HOUR 7	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18548 Brooke Rd				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Cement Finisher		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Mont	13c. CITY OR TOWN Sandy Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 18548 Brooke Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II			16b. SOCIAL SECURITY NO. 218-16-0032		17. INFORMANT NAME ADDRESS Estella Williams (wife) 18601 Brooke Rd, Sandy Sp. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John D. Pagan			TITLE (SPECIFY) Dep M.D.			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-29-87		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg, MD	
24. FUNERAL DIRECTOR NAME George R. Snowden			ADDRESS Rockville, MD 20850		25a. DATE RECEIVED BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Landolt	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

004204 209-581

064045 AUG 28 87

FOR STATE SB per Med. Exam
 1. Film 6031 9-3-87

STATE OF MARYLAND Item: 18a, 21a-f, 22 per ME0 G-757 3/25/98
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 4 0 9 3 reb
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Garrett Michael		FIRST Garrett Michael		MIDDLE Michael		LAST Wilson		2a. DATE KNOWN OF DEATH ESTIMATED 8-22-1987		2b. HOUR AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Mar 12, 1987		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 5		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 8-22-1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital		13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE (CITY LIMITS)? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Garrett E. Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Anastasi		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		12. INFORMANT Garrett E. Wilson, Father, see #13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Sudden Infant Death Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause <u>lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Hour: <u>unk.</u> date <u>8/22/87</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject was suffocated			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION CITY OR TOWN COUNTY STATE 11437 Applerath Way Germantown, Montgomery Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) Assistant M.D.				DATE SIGNED 8-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug 25, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR Rockville, Inc. 300 W. Montgomery Av., Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR AUG 26 1987				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE BODY.

07/84
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BP

DHMM - 17
(VR A15 ME (5))

064012 AUG 30 81

20% COLLOID 155B
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AUG 30 1981

062487 AUG 13 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24094
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Samuel W. Wilson			2a. DATE OF DEATH MONTH DAY YEAR 08 02 1987			2b. HOUR 11:57 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 21 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel W. Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Allie Wilson		13e. STREET ADDRESS / ZIP CODE 6500 Stratford Rd. 2815			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2 463-07-3172		17. INFORMANT ADDRESS Clara S. Wilson, 6500 Stratford Rd., Ch.Ch., Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Disease</u>		<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Atherosclerosis</u>		<u>years</u>

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Hypertension

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>75</u> , to <u>Aug 2</u> , 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>July 30</u> , 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <u>Haris W. Kenner, M.D.</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>8/2/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Haris W. Kenner, M.D.</u>				22e. ADDRESS <u>2342 Old Georgetown Rd Bethesda Maryland 20814</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-4-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort		23d. LOCATION (CITY OR TOWN) STATE Alexandria, Fairfax, Va.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons				ADDRESS 5130 Wis. Ave. N.W. Washington, D.C.		DATE REC'D. BY REGISTRAR AUG 12 1987	
25. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

062487 AUG 13 01

Arkansas

U.S.A.

U.S. Govt.

Physicist

6500 Stratford Rd.

Y

Gray House

Montgomery

Wilson

Allie

Mary

Wilson

W.

Samuel

6500 Stratford Rd., Ch. Ch., Md.

465-07-5175

U.S.A.

Yes

Remotion

8-7-87

Mt. Comfort

Alexandria, Fairfax, Va.

2150 W. Ave. N.W.

Washington, D.C.

Joseph Lawler's Sons

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24095
REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST William RODGERS Wilson		26. DATE OF DEATH		MONTH DAY YEAR 8 17 87		26. TIME 5:28 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY US Postal Ser.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Pr. Geos.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 902 Cox Avenue/20783				14. FATHER'S NAME FIRST MIDDLE LAST John M. Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Claudia -- Rodgers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Jeanette C. Wilson, Same address as #13.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA OF THE COLON</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF THE RIGHT COLON</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <u>2 weeks</u>									APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PERITONEAL CARCINOMATOSIS, ASCITIS.</u>									
19a. DATE OF OPERATION 8/3/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>SMALL BOWEL OBSTRUCTION DUE TO RECURRENT COLON CANCER</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>August 1, 1987</u> to <u>August 16, 1987</u> , that (I) (we) lost saw the deceased alive on <u>August 16, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Joseph Gawler</u>				DEGREE MD				22c. DATE SIGNED 8/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOVENAL R. GOICOHEA				22e. ADDRESS 8218 WISCONSIN AVE # 106, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24096
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth S. Wilton			2a. DATE OF DEATH MONTH DAY YEAR August 25, 1987		2b. HOUR 4:30p M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR December 14, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10401 Grovesnor Place #515		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator	12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Coale		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Not Available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577 01 1878		17. INFORMANT Ralph C. Wilton 3908 ADDRESS Shallow Brook Lane Olney, Maryland 20832	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholangiocarcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Biliary obstruction					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) XXXXXX attended the deceased from April 28, 1987, to August 26, 1987, that (I) (we) last saw the deceased alive on August 25, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22a. SIGNATURE Henry C. Scruggs M.D.				22c. DATE SIGNED August 26, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs M.D.				22e. ADDRESS 5413 Cedar Lane 206C Bethesda, Maryland 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE August 29 1987	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814			25. DATE REC'D. BY REGISTRAR AUG 31 1987		

25b. REGISTRAR'S SIGNATURE
Jillia Davidson-Rodriguez

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30% COTTON

AUG 31 1987

064344 SEP

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24097
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Wimbourne			2a. DATE OF DEATH MONTH DAY YEAR 08 26 87			2b. HOUR 11 ¹⁰ AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 24 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Diamond		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1900 Lyttonsville Road 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Emmanuel Wimbourne			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yetta Feinmesser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 078 28 9867		17. INFORMANT Jean E. Wimbourne (wife) See #13 above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>cardio myopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardio myopathy</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure & Diabetes</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8-25</u> 19 <u>87</u> to <u>10 YRS</u> 19 <u>87</u> that (I) (we) saw the deceased alive on <u>8-25</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Robert K. Zamer</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/26/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT K. ZAMER						22e. ADDRESS 10313 Georgia Ave S.E. 88286 MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 28 1987		23c. NAME OF CEMETERY OR CREMATORY King David Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME Ives-Pearson F. H. Falls Church, Va.						25a. DATE REC'D. BY REGISTRAR AUG 31 1987				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, or medical condition, a medical examiner must be notified at once.

BP

064344 SEP-1 61

Aug 31 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24098
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen S. Winkler			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1987		2b. HOUR A 3:45 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Chevy Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8809 Jones Mill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-Typist	12b. KIND OF BUSINESS OR INDUSTRY VA & NIH	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8809 Jones Mill Road / 20815
14. FATHER'S NAME FIRST MIDDLE LAST Bernhard Winkler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hermine Thalman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-38-3700	17. INFORMANT ADDRESS Fred B. Winkler, 8728 Susanna Lane Chevy Chase, MD 20815		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION January 17, 1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Pancreas		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (XXXXXX) attended the deceased from <u>November 59</u> to <u>August 23</u> , 19 <u>87</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>July 13</u> , 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <i>John B. Umhau</i>		DEGREE M.D.		22c. DATE SIGNED August 23, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau, M. D.		22e. ADDRESS 8805 Connecticut Avenue Chevy Chase, MD 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-23-87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc.		ADDRESS P. O. Box 43352, Washington, DC 20010		25a. DATE REC'D. BY REGISTRAR AUG 25 1987	25b. REGISTRAR'S SIGNATURE <i>John B. Umhau</i>

063829 AUG 26 87

063850 102501

062564 AUG 13 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24099
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL WINKLER			2a. DATE OF DEATH MONTH DAY YEAR 8-9-87		2b. HOUR 10⁵⁰ P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-9-1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retailer-Women's Apparel	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Winkler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 058 07 3298		17. INFORMANT Melvin Chernow		17a. ADDRESS 12412 Anislow Green Court Potomac, Md. 20854			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Probable Acute Pulmonary Emboli - 1 day DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimers Dementia 0700x 1040 PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from April 15, 1981 to August 9, 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Loretto S. Albion, MD				DEGREE MD		22c. DATE SIGNED 8-10-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETTO S. ALBION, MD				22e. ADDRESS 6121 MONTROSE RD			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Aug. 11, 1987		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Park		23d. LOCATION CITY Falls Church, Va. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Va. 22046				25a. DATE REC'D. BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

005201 AUG 13 03

COLLIER CEMENT

AUG 1 1903

63683 AUG 25 1987

Film G630 item 11, 17 per F.H.

FOR
STATE 8/24/87 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24100
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAELE B. WOLFE			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 20, 1987		2b. HOUR 4:00A M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 29, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2117 HERMITAGE AVENUE Hermitage Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY PA STATE	
13a. STATE FLORIDA		13b. COUNTY TAMPA		13c. CITY OR TOWN TAMPA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 4008 S. RENELLIE DRIVE 33611		14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL ROTTMANN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH ROUBISCHEK		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 280-18-3672		17. INFORMANT ADDRESS MARGARET M. BESMEN/ DAUGHTER SAME AS 13-11		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma colon DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from April 19 87 to Aug. 20 87 , that (I) (we) last saw the deceased alive on 8/19 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE John 2 Melnick us	
22c. DATE SIGNED 8/20/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN MELNICK		22e. ADDRESS 911 N. RUSSELL AVE. GAITHERSBURG, MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	
23b. DATE AUG 20, 1987		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901	
25a. DATE REC'D. BY REGISTRAR 08-28-87		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME		25d. REGISTRAR'S ADDRESS	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

003003 AUG 22 83



062174 AUG 10 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24101
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN WORTMAN			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 3 '87		2b. HOUR 8:50 A.M.						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK, EMPLOYER, OR BUSINESS) clerical (ret.)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8700 Jones Mill Road (20015)			
14. FATHER'S NAME FIRST MIDDLE LAST Morris Ruff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Piesachowitz				ADDRESS Bethesda, Md. 20814			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-46-7033		17. INFORMANT David Wortman; Son; 8621 Lancaster Drive;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ALZHEIMERS DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 5 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
CEREBRAL ARTERIOSCLEROSIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 3/17/82 19 82 to 8/3 19 87 , that (I) (we) lost saw the deceased alive on 8/3 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel J.N. Sugar				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL J.N. SUGAR				22e. ADDRESS 4637 EASTERN AVE MT RAINIER, MD 20712							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/5/87		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION (CITY OR TOWN) Falls Church; Fairfax; VA					
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852						25a. DATE RECEIVED BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1993 AUG 10 10 10 10

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062155 AUG 10 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 /

REG. NO. 24102

1. DECEASED NAME (TYPE OR PRINT) Ruth Eileen Wyman			2a. DATE OF DEATH MONTH DAY YEAR 8 1 1987 2b. HOUR 9:25 AM		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR December 9, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 299 Hurley Avenue / 20850		
14. FATHER'S NAME FIRST MIDDLE LAST Carl Davis Byrd			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Swafford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -	17. INFORMANT 218-38-8616	ADDRESS 33 Patti Lynn Lane Houston, Texas		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Alphavirus disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 16</u> , 19 <u>87</u> , to <u>Aug 1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE <u>Blaine H. Eig</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Aug 1, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE H. EIG		22e. ADDRESS 9801 GEORGIA AVE SILVER SPRING MD, 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE August 4, 1987	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD. 20814		25a. DATE REC'D. BY REGISTRAR AUG 7 1987			
25b. REGISTRAR'S SIGNATURE Julia Tidwell-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

065122 AUG 10 63



064829 SEP-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

24103

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		2b. MONTH	2c. DAY	2d. YEAR	2e. HOUR
Ochie				Yamada	ESTIMATED		<input checked="" type="checkbox"/>	8	30	1987
2a. DATE KNOWN OF DEATH		2b. MONTH		2c. DAY		2d. YEAR		2e. HOUR		
Ochie		YAMADA		8		30		1987		04:30 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD		10. MONTH		11. DAY
Female	ORIENTAL	06 04 93	94 YRS.			08 30		1987		04:30 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
JAPAN	U.S.A.				MONTGOMERY MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA	SUBURBAN HOSPITAL		HOUSEWIFE		AT HOME					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
MD	MONTGOMERY	BETHESDA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6924 CARMICHAEL AVE		20817			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
TAKENOSUKE - MIZUHARA				NOBU - KATO						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO				084-68-4183		LILY TANAKA, SAME AS #13				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		ACUTE
DUE TO, OR AS A CONSEQUENCE OF		
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INDEF
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	PM P.M. 08 29 1987	FOUND IN BOX
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION
	HOME	6924 CARMICHAEL AVE BETHESDA MONT MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED
Francis C. Mayle	DEPT	8/30/87
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	
FRANCIS C. MAYLE	820 Wisconsin Ave Bethesda MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Cremation	8/31/87	Mt. Comfort Crematory	Alexandria, VA
24. FUNERAL DIRECTOR NAME		25. DATE REC'D BY REGISTRAR	
Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave, NW, Washington, D.C. 20016		SEP 04 1987	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. REMAIN PAGES 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84
25M

BP

DHMH - 17
(VR A15 ME (5))

004822 28-9-61

Yours

Yours

Yours



SEP 04 1961

2130 Anderson Ave., New York 10023

064443 SEP - 187

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH24104
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE KATHERINE LAST YATES			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 24, 1987		2b. HOUR 6:40 P M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 25, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY HECHTS
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2407 RANDOLPH ROAD 20906	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH H. HIGGS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA L. THOMPSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-3278		17. INFORMANT ADDRESS ANNETTE ROMANESK/DAUGHTER SAME AS 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Generalized Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CVA. 1985</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 23</u> 19 <u>87</u> , to <u>Aug 24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Aug 24</u> 19 <u>87</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Herbert Baraf</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>8/25/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT BARAF		22e. ADDRESS 10313 GEORGIA AVE. SILVER SPRING, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE AUG27, 1987	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN	23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MARYLAND
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 31 1987 <u>Julia Davidson-Rodriguez</u>	
500 UNIVERSITY BLVD. W SILVER SPRING, MD 20901			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

184-932 E 44 2

AUG 21 1967

064483

SEP-28-1987

FOR
STATE
REGISTERSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

24105

1. DECEASED NAME (TYPE OR PRINT) Rose Yates			2a. DATE OF DEATH MONTH DAY YEAR 8-28-87			2b. HOUR 10:30 P. M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 16 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10. CITY OR TOWN OF DEATH SANDY SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIENDS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Mont.		13c. CITY OR TOWN Brinklow		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 59 20862	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Emil Bucher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				
16b. SOCIAL SECURITY NO. 138 03 9661			17. INFORMANT (Nephew) Walter Bucher			17b. ADDRESS Same as 13E			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic CV Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA 1983 Osgood-Ram Syndrome</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from 8/28/87 to 8/28/87, that (I) (we) last saw the deceased alive on 8/28/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)				
22a. SIGNATURE C. H. L. 15/87		22b. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. L. 15/87		22c. ADDRESS 18111 P. Philip Dr., Olney, MD 20832		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 8/28/87		
23a. BURIAL, CREMATION, REMOVAL (15b) Burial		23b. DATE 9/1/87		23c. NAME OF CEMETERY OR CREMATORY Atlantic City Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pleasantville, N.J.				
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR SEP 1 1987		25b. REGISTRAR'S SIGNATURE John Anderson-Randall				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or any significant event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Department of Health and Mental Hygiene prior to burial or cremation, or removal with the State Dept. of Health and Mental Hygiene.

004483 25-581

062830

FOR
AUG 17 87STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2 4 1 0 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John John		FIRST John MIDDLE Willard LAST YOKLEY YOKLEY		20. DATE OF DEATH MONTH DAY YEAR August 12, 1987		2b HOUR 4:30 AM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 2 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17060 King James Way, Apt. 504		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Highway Main.		12b. KIND OF BUSINESS OR INDUSTRY County Roads	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Percy Yokley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Mae Brown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW 2		16b. SOCIAL SECURITY NO. 579-18-2041	
17. INFORMANT Lillie J. Majors, Gaithersburg, Md. 20877		17. INFORMANT 11 Chestnut St., Gaithersburg, Md. 20877		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic cancer of colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Generalized Atherosclerosis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/11/80</i> 19 <i>78</i> , to <i>8/8</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>5/8</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Jules R. Lodish</i> MD				DEGREE MD		22c. DATE SIGNED 8/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules R.. LODISH, M.D.				22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Boysds Presbyterian		23d. LOCATION CITY OR TOWN COUNTY STATE Boysds, Montgomery, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR AUG 14 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1, 2, and 3 to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

005030 AUG 12 84

AUG 12 1984

FOR
STATE
ADMINISTRATOR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

H2 4 1 0 7

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Lauren Elizabeth Zaal								8/13		19		87							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female		White		Apr. 3, 1987		4 YRS. 10 MONTHS		4		10		8/13		19		87		2:40 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Texas				USA								Montgomery County							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Olney				Montgomery General Hospital								N/A							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Texas				Collin				Plano				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2504 Rothland Lane 75023			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
T. Andre Zabl				Cindy Fox															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
no				none				Zaal / Andre Zabl same as above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Congenital heart disease (Trisomy-18).																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
None																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
None														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19				None											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
								CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED							
John S. Rogers, M.D.				Deputy				1919 Seminary Road				8/13/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John S. Rogers, M.D.				Silver Spring, Montgomery County, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				Aug 15, 1987				Most Holy Name Cemetery				Mount Troy PA							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Donaldson Funeral Home P.A.				Laurel, Maryland				AUG 19 1987				Donaldson-Randall							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. GIVE PAGES 6 AND 7 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 501 W. BEESON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP 77
DHWH - 8
(VR A15 ME (5))

063307 AUG 21 57

x

87

873

last

Lizabeth

Lauren

04:40

87

873

10

Apr. 2, 1957

White

Female

x

Montgomery County

Montgomery General Hospital

Olney

2504 Robinson Lane

Flano

Texas

Congenital heart disease (Tricuspid-18).

None

None

x

None

x

x

8/13/57

Deputy

1913 Seminary Road

Silver Spring, Montgomery County, MD

John B. Rogers, M.D.

064330 SEP -1 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

24108

1- STATE
REGISTRAR

1. DECEASED NAME FIRST Rose MIDDLE A. LAST Zalonis				2a. DATE KNOWN OF DEATH MONTH 8 DAY 26 YEAR 1987				2b. HOUR 8:30 A.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Jul. DAY 15 YEAR 1906	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD MONTH 8 DAY 26 YEAR 1987		2d. HOUR A.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7051 Carroll Avenue, #213				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY (RET)		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7051 Carroll Avenue, #213	
14. FATHER'S NAME FIRST PAUL MIDDLE LAST MATUSAVAGE				15. MOTHER'S MAIDEN NAME FIRST NOT MIDDLE AVAILABLE LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 209-16-3527		17. INFORMANT ADDRESS PETER J. ZALONIS, Rt 2, Box 643 PUEBLOVILLE VA 22132					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Acute myocardial disease.**

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)
DUETO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

None

19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE
SIGNED

8/26/87

EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, M.D.

ADDRESS

**1919 Seminary Road
Silver Spring, Montgomery County, MD**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 29, 1987		23c. NAME OF CEMETERY OR CREMATORY ST. CASIMIR'S CEMETERY		23d. LOCATION CITY OR TOWN MUHLBURG COUNTY FA STATE PA	
24. FUNERAL DIRECTOR Takoma Funeral Home		ADDRESS 254 Carroll Ave NW		25. DATE RECEIVED BY REGISTRAR AUG 31 1987		26. REGISTRAR'S SIGNATURE John S. Rogers	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. PAGE 5, FOR YOUR FILES, TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

064330 SEP-187

Rose

Alabama

x

Female White Jul. 12, 1906 31

Montgomery County

Lakona Park 7021 Carroll Avenue, W.D.

Lakona Park Montgomery Maryland 7021 Carroll Avenue, W.D.

Acute myocardial disease.



None

None

None

x

x

John S. Rogers, M.D.
Silver Spring, Montgomery County, MD
1019 Seminary Road
Dulles, VA
8/26/87

AUG 27 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				24109	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOLLIE M ZAVAN			2a. DATE OF DEATH MONTH DAY YEAR 8/13/87		2b. HOUR 11:4 AM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 4/08/07		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13701 Middlevale Lane (20906)
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Fuchs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Strudler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 174-26-7259		17. INFORMANT ADDRESS Herbert Roseman; Son-in-Law; 13701 Middlevale Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF STOMACH & METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 MONTH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHOLECYSTITIS & STONES					
19a. DATE OF OPERATION 9/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED STOMACH CANCER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 87 8/13 87	
22a. I certify that (1) (this hospital) attended the deceased from 8/13/87 to 8/13/87 , that (1) (we) lost saw the deceased alive on 8/13/87 above (1) (we) (did) (did not) view the body after death and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE OF PHYSICIAN David Goldberg DEGREE					22c. DATE SIGNED 8/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID GOLDBERG					22e. ADDRESS 9801 GREENBANK SILVER SPRING, MARYLAND
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/16/87		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn.; Falls Church; Fairfax; Va.	
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS NAME ADDRESS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) AUG 17 1987 <i>Julia Davidson-Henderson</i>	

BP _____

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